Arkansas Medicaid Prescription Drug Program

Synagis® Prior Authorization (PA) Request Form (Year 2024-25)

Fax this form to 1-800-424-7976. For questions, call 1-800-424-7895.
After completing the information below, please fax to the Pharmacy PA Center.

Synagis® (palivizumab) is a humanized monoclonal antibody produced by recombinant DNA technology that is indicated for the prevention of serious lower respiratory tract diseases caused by respiratory syncytial virus (RSV). Beyfortus™ (nirsevimab) is a VFC benefit for Arkansas Medicaid beneficiaries. Documentation of the medical necessity of Synagis® over Beyfortus™ is required.

PRESCRIBER

For Arkansas, the typical RSV season runs from November 1 to March 31. Based on AAP, ACIP, and CDC guidance, season duration and approval criteria may change. A maximum of five doses will be approved per beneficiary. The administration of only one dose of Synagis® will be approved per calendar month. The last dose must be administered to the patient before March 31, 2025. The Synagis® Prior Authorization (PA) Request Form is expected to be completed by the prescriber or their assigned staff personnel and signed by the prescriber. Signature of a pre-completed form received by an outside party is not encouraged and may result in an audit. Additional information may be requested, such as a discharge summary.

The recommended Synagis® dose is based on weight at 15 mg/kg. Prescribe minimum units necessary for the dosage. If approved, you will receive a Synagis® approval confirmation fax requesting the appointment date for the first dose. Authorization for each monthly dose will require submission of the previous month's approval fax with the requested information. At least one week prior to the expected appointment (i.e., not the day of the appointment), the clinic will need to send in verification that the beneficiary has an appointment scheduled for the administration of Synagis®. Arkansas Medicaid will authorize the appropriate strength and notify you and the pharmacy indicated on the Synagis® PA Request Form that the pharmacy may bill during the authorized dates.

Please note: A second RSV season will only be considered for chronic lung disease (CLD) of prematurity based on the 2014 AAP Guidelines: "A second season of palivizumab prophylaxis is recommended only for preterm infants born at < 32 weeks, 0 days' gestation who required at least 28 days of oxygen after birth and who continue to require supplemental oxygen, chronic systemic corticosteroid therapy, or bronchodilator therapy within 6 months of the start of the second RSV season."

PHARMACY

Always file claims with the primary insurance before billing Arkansas Medicaid. Synagis® PA approval does not ensure Arkansas Medicaid eligibility. Synagis® dosage is based on 15 mg/kg. Dispense the minimum units necessary for the dosage. Pharmacies will be subject to audit to ensure the NDC(s) dispensed will total the dosage closest to the dosage required. Overbilled units are subject to recoupment. Weight changes requiring PA adjustment can be coordinated with the Prime Therapeutics State Government Solutions LLC Help Desk. Each PA will be set up one week prior to the expected appointment. The clinic will need to send in verification that the beneficiary has an appointment scheduled for the administration of Synagis® before the PA for that dose will be entered.

Print Reset

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Dispensing Guide:

Weight	Dosage	Dispense Units
Up to 3.3 kg	Up to 49.5 mg	1 x 50 mg vial
3.4 kg to 6.6 kg	51 mg to 99 mg	1 x 100 mg vial
6.7 kg to 10 kg	100.5 mg to 150 mg	1 x 100 mg vial + 1 x 50 mg vial
10.1 kg to 13.3 kg	151.5 mg to 199.5 mg	2 x 100 mg vials
13.4 kg to 16.6 kg	201 mg to 249.5 mg	2 x 100 mg vials + 1 x 50 mg vial
16.7 kg to 20 kg	250.5 mg to 300 mg	3 x 100 mg vials

Note: Synagis® is to be given every 28–30 days during RSV Season. The typical RSV season is November through March. Compliance with all of the specific criteria listed on these pages is a condition for payment by Arkansas Medicaid. **Documentation of the medical necessity over Beyfortus™ (nirsevimab) is required.**

The form on this page is to be **completed** by and **received** from the prescribing provider. The form will not be accepted from the providing pharmacy. Please fax this completed form to the Pharmacy PA Center for evaluation and processing. **Complete all sections**. Information contained in this form is Protected Health Information under HIPAA.

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

Medicaid ID: _____ Date of Birth: _____

Birth Weight: _____ kg Current Weight: _____ kg Date Measured: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ Office Contact: _____

Prescriber Phone: _____ Prescriber Fax: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Fax: _____

DRUG INFORMATION

Drug Name: **Synagis®**

Drug Strength: ☐ 50 mg ☐ 100 mg

Note: Please continue to the next page (page 3) to complete the approval criteria for this Prior Authorization request.

Beneficiary's Name: _____

CRITERIA

☐ Prescriber has submitted documentation of medical necessity of Synagis® over Beyfortus™ (nirsevimab) with discharge summary and current chart notes.

☐ Prescriber attestation that the beneficiary **has not** received Beyfortus™ (nirsevimab) or Abrysvo™ (maternal RSV vaccine) this RSV season, **and** WebIZ has been checked.

☐ Prescriber attestation that Beyfortus™ availability has been checked at local VFC providers and product is **not** available.

Select **one** of the following criteria the patient currently meets to be considered for RSV prophylaxis:

1. ☐ Chronic lung disease (CLD) of prematurity **and** < 2 years of age at start of RSV season. CLD of prematurity is defined as gestational of age < 32 weeks, 0 days, and a requirement for > 21% oxygen for at least the first 28 days after birth. A second season of palivizumab prophylaxis is recommended only for infants with CLD of prematurity as defined above and who continue to require supplemental oxygen, chronic systemic corticosteroid therapy, diuretic therapy, or bronchodilator therapy during the 6-month period before the start of the second RSV season.
2. ☐ Former premature (≤ 28 weeks, 6 days estimated gestational age [EGA]) **and** < 12 months of age at the start of RSV season. For infants born during the RSV season, fewer than 5 monthly doses will be needed.
3. ☐ Infants ≤ 12 months of age at start of RSV season with hemodynamically significant congenital heart disease (CHD). Children who meet these criteria will be **a)** infants with acyanotic heart disease who are receiving medication to control congestive heart failure and will require cardiac surgical procedures and **b)** infants with moderate-to-severe pulmonary hypertension. Infants with cyanotic heart defects in the first year of life will be reviewed on a case-by-case basis.
4. ☐ Infants < 12 months of age at start of RSV season with neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough.
5. ☐ Severely immunocompromised **and** patient is < 2 years of age.
6. ☐ Certain Cystic Fibrosis infants and American Indian/Alaskan Native infants (per 2023-2024 ACIP and AAP joint recommendations).

****Note**: If none of the above criteria are met, provider must submit a letter of medical necessity. These letters may be faxed to the DMS Pharmacy Unit at 800-424-5851.

Prescriber Signature: _____ **Date:** _____

(**Prescriber's original signature required; copied, stamped, or e-signature are not allowed**. By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to – ATTN: Pharmacy PA Center – Fax: 1-800-424-7976