OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare Synagis® (Palivizumab) Continuation Form

Please Note: This form is for continuation of Synagis® therapy only.
This form should only be submitted following initial approval of Synagis® during the current RSV season in Oklahoma. Each approval will be for a duration of 1 month. Subsequent approval consideration will also require use of this form and will only be granted monthly during the current RSV season in Oklahoma.

For initial Synagis® approval consideration, please submit the Synagis® (Palivizumab) Initiation Prior Authorization Form (PHARM-7A) which is available on the OHCA website at: https://oklahoma.gov/ohca/providers/forms/rxforms.html.

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

FDA approved dosing:15mg/kg intramuscularly. Only those doses that require greater than a vial's dose +10% may use the next vial size or an additional vial (e.g. 1-55mg = 50mg vial, 56-110mg = 100mg vial). Weight must be taken within the last 3 weeks. Each dose is to be given every 30 days.

Physician billing ☐ CPT code 90378 (50mg/unit)
Pharmacy billing ☐ 50mg/0.5ml NDC:_____ ☐ 100mg/ml NDC:_____

Billing Provider Information

Provider:_____ Provider NPI:_____
Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber:_____ Prescriber NPI:_____
Prescriber Phone:_____ Prescriber Fax:_____

Synagis® Continuation Information

For continued authorization of Synagis®, please provide <u>all</u> of the following:

1. Previous Dose Information:
   a. Date last dose of Synagis® was received:_____
      (each dose is to be given every 30 days)
   b. Dose of last Synagis® injection:_____ (mg)
2. Current Weight Information:
   a. Member's current weight:_____ (kg)
   b. Date member's weight was recorded:_____
      (weight must be taken within the last 3 weeks)
3. Has the member received Beyfortus™ (nirsevimab-alip)? Yes☐ No☐
4. Please provide a patient-specific, clinically significant reason why the member cannot receive Beyfortus™ (nirsevimab-alip):_____

_____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114, Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*