



# RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS

**Fax completed form to:  
888-466-2778**

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (+Area Code) \_\_\_\_\_ Other Telephone Contact (+Area Code) \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Sex  M  F

Parent/Guardian \_\_\_\_\_

## INSURANCE INFORMATION

Include copies of the patient's insurance cards and drug benefit cards (front & back), if available.

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Cardholder Name & SSN (If not patient) \_\_\_\_\_ Cardholder Name & SSN (If not patient) \_\_\_\_\_

Policy Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Insurance Telephone Number (+Area Code) \_\_\_\_\_ Insurance Telephone Number (+Area Code) \_\_\_\_\_

## PHYSICIAN INFORMATION

Prescriber's Name \_\_\_\_\_ Hospital/Clinic \_\_\_\_\_ Office Contact \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Telephone Number (+Area Code) \_\_\_\_\_

Prescriber's License Number \_\_\_\_\_ DEA Number \_\_\_\_\_ Fax Number (+Area Code) \_\_\_\_\_

Medicaid Provider Number \_\_\_\_\_ UPIN Number \_\_\_\_\_

## Rx

Synagis® (palivizumab) injection  
Sig: Inject 15 mg/Kg IM one time each month for \_\_\_\_\_ months

Pediatric Anaphylaxis Kit / For Home Administration Only  
Sig: Inject as directed per ACLS/PALS protocol.

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## STATEMENT OF MEDICAL NECESSITY

### PRIMARY DIAGNOSIS

Patient's Gestational Age: \_\_\_\_\_ Birth Weight \_\_\_\_\_ (kg only)

Current Weight \_\_\_\_\_ (kg only) Date Recorded \_\_\_\_\_ Allergies \_\_\_\_\_

- Congenital Heart Disease (747-745.49)  29-30 weeks of gestation (765.25)
- Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)
- ≤24 weeks of gestation (765.21-765.22)  31-32 weeks of gestation (765.26)
- 25-26 weeks of gestation (765.23)  33-34 weeks of gestation (765.27)
- 27-28 week of gestation (765.24)  35-36 weeks of gestation (765.28)
- Congenital Abnormality of Respiratory System (770.0-770.9)
- Other Respiratory Conditions of Fetus & Newborn  37 weeks of gestation (765.29)
- Other \_\_\_\_\_ Secondary diagnosis (if applicable) \_\_\_\_\_

### MEDICAL CRITERIA

1. Diagnosis of Chronic Pulmonary Disease (CLD/BPD) and less than 24 months of age?

Yes  No

Is patient receiving medical treatment of (check all that apply and provide last date received):

Oxygen Date: \_\_\_\_\_  Corticosteroids Date: \_\_\_\_\_

Bronchodilator Date: \_\_\_\_\_  Diuretics Date: \_\_\_\_\_

2. Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age?  Yes  No

Patient has the following condition:  Diagnosis of moderate-severe pulmonary hypertension

Medications for CHD: \_\_\_\_\_ Last date received: \_\_\_\_\_

3. Prematurity:

Gestational age of ≤28 weeks and <12 months of age at the start of RSV season

Gestational age of 29-32 weeks and <6 months of age at the start of RSV season

Gestational age of 32-35 weeks and <6 months at the start of the RSV season

Clinically has the following risk factors (Check all that apply)

Need two:

School age siblings

Exposure to environmental air pollutants

Day Care

Severe neuromuscular disease

Congenital abnormality of airway

Others that may apply:

Birth weight less than 2500 grams

Crowded living conditions

Multiple birth

Family history of asthma

Other medical history: \_\_\_\_\_

NICU HISTORY:  Yes  No Please attach the NICU Discharge Summary

Was there a NICU/HOSPITAL dose administered?  No  Yes Date(s): \_\_\_\_\_

**EXPECTED DATE OF FIRST/NEXT INJECTION:** \_\_\_\_\_

Deliver product to:  Office  Patient's Home  Nursing Agency

Name of Agency to administer injection at patient's home: \_\_\_\_\_

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