SYNAGIS® PALIVIZUMAB

STATEMENT OF MEDICAL NECESSITY

RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS

Complete form in its entirety and fax to number listed below.

1 PATIENT INFORMATION

Last Name | First Name | Middle Initial

Street Address | City

County | State | ZIP code

Date of Birth | Sex ☐ **M** ☐ **F**

Primary Guardian | Secondary Guardian

Day Telephone (+ Area Code) | Night Telephone (+Area Code)

INSURANCE INFORMATION

Include copies of the patient's insurance cards and drug benefit cards (front and back) to expedite benefit clearance.

Primary Insurance | Secondary Insurance

Cardholder name | Cardholder name

Group Number | Group Number

Member ID | Member ID

2 PHYSICIAN INFORMATION

Prescriber's Name | Hospital/Clinic/Office | Office Contact

Address | City/State/ZIP | Telephone Number (+Area Code)

Prescriber's License Number | DEA/NPI Number | Fax Number (+ Area Code)

Medicaid Provider Number | NPI Number

Supervising Physician's Name (If required for mid-level Practitioner) | License Number

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Fax completed form to:

MVP HEALTH CARE

Commercial **1-800-376-6373**

Medicare Part D **1-800-401-0915**

All referrals are subject to the 2009 AAP Guidelines

3 CLINICAL INFORMATION

PATIENT'S GESTATIONAL AGE (GA) _____Weeks _____ Days

GESTATIONAL AGE (GA) ICD-9 code: _____

BIRTH WEIGHT _____kg or _____lbs

CURRENT WEIGHT _____kg, or _____ lbs DATE RECORDED _____

Check appropriate boxes below:

1. ☐ Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age, requiring medical therapy within 6 months before anticipated RSV season. Provide chart notes if requesting a second season.
ICD-9 code: _____ Diagnosis: _____
Receiving medical treatment/therapy of: (check all that apply & provide last date received):
☐ Oxygen Date: _____ ☐ Corticosteroids Date: _____
☐ Bronchodilator Date: _____ ☐ Diuretics Date:_____

2. ☐ Diagnosis of hemodynamically significant congenital heart disease (CHD), CHF requiring medications, cyanotic CHD, moderate-severe pulmonary hypertension <24 months of age at onset of first RSV season.
ICD-9 code: _____ Diagnosis: _____
☐ Medications for CHD:_____
☐ Surgical Correction

3. Prematurity: ☐ Gestational age of ≤ 28 weeks,6 days & <12 months of age at start of first RSV season;
☐ Gestational age of 29-31weeks, 6 days & <6 months of age at start of first RSV season;
☐ Gestational age of 32-34weeks, 6 days & <3 months of age at start of first RSV season
(max of 3 doses up to age 90 days), AND:
The following risk factors (check all that apply):
☐ School-age siblings < 5 years old &living in household
☐ Attends childcare
☐ Gestational age of < 32-34 weeks, 6 days and <12 months of age, AND have either congenital abnormalities of the airway or a severe neuromuscular disease.
ICD-9 code: _____ Diagnosis: _____

4. NICU/HOSPITAL HISTORY:
- Did the patient spend time in the NICU or Special Care Nursery? ☐ Yes (attach d/c summary) ☐ No
- Was RSV prophylaxis recommended by the NICU/HOSPITAL physicians for this patient? ☐ Yes ☐ No
- Was there a NICU/HOSPITAL dose administered? ☐ Yes Date(s):_____ ☐ No
- EXPECTED DATE OF FIRST/NEXT INJECTION:_____
- Dates of previous injections. Date(s):_____

5. Deliver product to: ☐ Patient's Home
☐ Office Office Location: _____
☐ Clinic Clinic Location:_____
Agency nurse to visit home for injection: ☐ Yes ☐ No Preferred Agency_____

Rx
☐ **Synagis® (palivizumab)** 50- and/or 100-mg vials
Sig: Inject 15 mg/kg IM one time per month (every 28-30 days)
Dispense Quantity: QS Refills: _____
☐ **Epinephrine** 1:1000 amp. Sig: Inject 0.01 mg/kg as directed ☐ Known Allergies:_____

Prescriber's Signature_____ Date_____

- Unless otherwise noted above, 5 doses is the maximum allowed amount.

Effective December 1, 2009