STATEMENT OF MEDICAL NECESSITY

RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS

For Questions, Please Call: **877.796.2447**

Are you referring this patient from a *NICU/HOSPITAL?* ❑ Y ❑ N

PATIENT INFORMATION

Last Name	First Name	Middle Initial ❑ M ❑ F	
Street Address		City	
County		State	ZIP Code
Date of Birth	Birth Weight (kg/lb)	Social Security #	
Parent/Guardian		Primary Language Spoken	
Day Telephone (+Area Code)		Cell/Night Telephone (+Area Code)	

PATIENT INSURANCE

Primary Insurance Plan	Phone (back of card)
Policy ID #	Group #
Policy Holder Name / Date of Birth	
Secondary Insurance Plan	Phone (back of card)
Policy ID #	Group #
Policy Holder Name / Date of Birth	Employer

PRIMARY DIAGNOSIS

Patient's Gestational Age (GA) _____weeks Birth Weight _____ ❑ kg ❑ lbs.

Current Weight_____ ❑ kg ❑ lbs. Date Recorded _____ / _____ / _____

❑ Congenital Heart Disease (Q20.0 - Q28.9)

❑ Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (P27.0; P27.1; P27.8)

❑ *Less than or equal to* 24 weeks GA (P07.2; P07.22; P07.23)

❑ 25-26 weeks GA (P07.24 ; P07.25)

❑ 27-28 weeks GA (P07.26 ; P07.31)

❑ Other Respiratory Conditions of Fetus and Newborn (P27.0; P27.1; P27.8)

❑ Other _____

❑ 29-30 weeks GA (P07.32; P07.33)

❑ 31-32 weeks GA (P07.34; P07.35)

❑ 33-34 weeks GA (P07.36; P07.37)

❑ 35-36 weeks GA (P07.38 ; P07.39)

❑ 37 or more weeks GA _____

❑ Congenital Anomalies of Respiratory System (Q30.0)

❑ Secondary Diagnosis (if applicable)_____

MEDICAL CRITERIA

1. Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age? ❑ Yes ❑ No
2. Diag. of hemodynamically significant congenital heart disease and less than 24 months of age? ❑ Yes ❑ No
3. Prematurity:
   - ❑ Gestational age of less than 28 weeks and *less than* 12 months of age at the start of RSV season
   - ❑ Gestational age of 29-32 weeks and *less than* 6 months of age at the start of RSV season
   - ❑ Gestational age of 32-35 weeks and *less than or equal to* 3 months of age at the start of RSV season
   - ❑ Gestational age of 32-35 weeks and *greater than* 3 *months but less than or equal to* 6 months of age at the start of RSV season

Patient Allergies: _____

Clinically has the following risk factors (check all that apply):

- ❑ School-age siblings
- ❑ Exposure to environ. air polluants
- ❑ Day care
- ❑ Severe neuromuscular disease (ICD-10 code:_____)
- ❑ Congenital abnormality of airway
- ❑ Birth weight less than 2500g
- ❑ Crowded living conditions
- ❑ Day care
- ❑ Family history of asthma
- ❑ Other

❑ Other medications patient is currently taking (including OTC medications) with dosage and direction (or fax medication profile):

NICU HISTORY

Did the patient spend time in the NICU? ❑ Yes ❑ No If yes, please attach NICU Discharge Summary.

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

PRESCRIPTION INFORMATION

First/Next Injection Due Date: _____ **Delivery and administration location: ❑ MD Office ❑ Patient Home ❑ Clinic**

❑ Check if AcariaHealth is to coordinate home nursing, please provide: Agency Name_____ **Phone #:** _____

❑ Check If home nursing is already established, please provide: Agency Name_____ **Phone #:**_____

❑ Synagis® (palivizumab) 50 and/or 100 mg vials ***(Will dispense 50 mg/0.5 ml and/or 100 mg/ml vial(s) based on prescribed dose)***

Sig: Inject 15 mg/kg IM every 28 days. (Dose to be calculated at time of injection, based on patient's current weight)

Quantity: QS Refills:_____ **❑ Refills through** _____

To dispense the prescribed dose required at the time of injection, the patient's weight will be estimated as per standard operating procedure.

❑ **Syringes** 1 ml 25G 5/8" (to withdraw) ❑ **Needles** (to inject) Gauge: 25 Length: 5/8" Quantity: QS (for both syringes & needles)

❑ **Epinephrine** 1:1000 amp (if required for home administration).
Sig: Call 911 & MD then Inject 0.01 mg/kg_____ mg SQ x1, may repeat as needed for anaphylaxis as directed # 3 amps Qty_____ Refills_____

❑ **Other**_____ Qty_____ Refills_____

PHYSICIAN INFORMATION

Practice Name	Synagis Contact Name	Prescriber's Name	Specialty
Prescriber's State License #	DEA#	Phone #	Fax #
Medicaid Provider #	NPI#	Address	City / State / ZIP

Prescriber's Signature_____ **Date**_____

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. **IMPORTANT NOTICE:** This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document.