

**STATEMENT OF MEDICAL NECESSITY**

RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS  
FAX COMPLETED FORM TO RSV CONNECTION AT: 866-252-1749  
FOR QUESTIONS, CONTACT RSV CONNECTION AT: 877-rsv-9010



Phone: 1-866-807-0516

**1-800-784-6283**

Preferred Specialty Pharmacy

Fax Number (+ Area Code)

**2 PATIENT INFORMATION**

Last Name	First Name	Middle Initial
Street Address		Apartment #
City	State	Zip Code
/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
Date of Birth	Sex	Known Allergies
Parent/Guardian	Secondary Guardian / Contact	
( ) -	( ) -	
Day Telephone (+Area Code)	Night or Alternate 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 Medical Insurance	Pharmacy Insurance
Member ID# / Policy #	Member ID# / Policy #
Group #	Group #
( ) -	( ) -
Insurance Telephone Number (+Area Code)	Insurance Telephone Number (+Area Code)
Primary Policy Holder / Cardholder Name	Policy Holder Social Security
Secondary Medical Insurance	Secondary Insurance Policy Holder Name

Employer	IPA
----------	-----

**3 PHYSICIAN INFORMATION**

Prescriber's Name	Office Contact		
Practice Name			
Address	Suite #		
City	State	Zip Code	
( ) -	( ) -	-	
Telephone Number	Fax Number		
DEA #	NPI#	Medicaid #	Prescriber's License #

**CLINICAL INFORMATION**

**PRIMARY DIAGNOSIS**

PATIENT'S GESTATIONAL AGE (GA): \_\_\_\_\_ BIRTH WEIGHT: \_\_\_\_\_ kg or \_\_\_\_\_ lbs

CURRENT WEIGHT: \_\_\_\_\_ kg or \_\_\_\_\_ lbs DATE RECORDED: \_\_\_\_/\_\_\_\_/\_\_\_\_

Congenital Heart Disease (747.0-747.9)  29-30 weeks' GA (765.25)

Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)  31-32 weeks' GA (765.26)

≤24 weeks' GA (765.21-765.22)  33-34 weeks' GA (765.27)

25-26 weeks' GA (765.23)  35-36 weeks' GA (765.28)

27-28 weeks' GA (765.24)  37 or more weeks' GA (765.29)

Other Respiratory Conditions of Fetus and Newborn (770.0-770.9)  Congenital Anomalies of Respiratory System (748)

Other \_\_\_\_\_ ( ) Secondary diagnosis (if applicable) \_\_\_\_\_ ( )

Description ICD-9 Description ICD-9

**MEDICAL CRITERIA:**

- Diagnosis of Chronic Pulmonary Disease (CLD/BPD) and <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: \_\_\_\_\_
- Diagnosis of hemodynamically significant congenital heart disease and <24 months of age?  Yes  No  
Patient has the following condition:  
 Medications for CHD: \_\_\_\_\_ Last date received: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Diagnosis of moderate-severe pulmonary hypertension  Cyanotic CHD
- Clinically has the following risk factors (check all that apply)
 

<input type="checkbox"/> Yes School-age siblings	<input type="checkbox"/> Yes Young chronologic age ≤ 12 weeks
<input type="checkbox"/> Yes Daycare attendance	<input type="checkbox"/> Yes Crowded living conditions
<input type="checkbox"/> Yes Exposure to environmental air pollutants	<input type="checkbox"/> Yes Exposure to environmental tobacco smoke
<input type="checkbox"/> Yes Severe neuromuscular disease	<input type="checkbox"/> Yes Birth weight < 2500 grams
<input type="checkbox"/> Yes Congenital abnormality of airway	<input type="checkbox"/> Yes Multiple birth
<input type="checkbox"/> None	<input type="checkbox"/> Yes Family history of asthma or wheezing
	<input type="checkbox"/> Yes Residency in rural setting

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

**NICU / HOSPITAL HISTORY**

Did the patient spend time in the NICU or Special Care Nursery?  Yes  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:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Injection already given?  No  Yes Date(s): \_\_\_\_\_

Deliver product to:  Office  Patient's Home  Clinic Location \_\_\_\_\_

Agency Nurse to visit home for injection:  Yes  No  
Agency Name: \_\_\_\_\_ Agency Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_

**Rx**  
**Synagis<sup>®</sup> (palivizumab) 50mg and / or 100 mg vials**  
Sig: Inject 15 mg/kg IM every 28-30 days Refills: 6 or \_\_\_\_\_  
Dispense Quantity: QS for weight based dosing

Epinephrine 1:1000 ampule (Required if using Home Healthcare Agency for Administration)  
Sig: Inject 0.01mg/kg as directed for severe reaction to Synagis Refills: 0

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(stamped or co-signed signatures not accepted) (date required for valid Rx)