



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 <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth	Social Security Number	Sex
Parent/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 & Social Security Number (If Not Patient)	Cardholder Name & Social Security Number (If Not Patient)
Group Number	Group Number
Policy Number	Policy Number
Insurance Telephone Number (+Area Code)	Insurance Telephone Number (+Area Code)
Employer	

2 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	
Supervising Physician's Name (If Required for Mid-Level Practitioner)		License Number

3  Fax to 4D Pharmacy Management for authorization: 248.540.9811

Drug provided by:
McKesson Specialty Pharmacy Services
 Fax: 1.888.591.8482, Phone: 1.888.456.7274



4 CLINICAL INFORMATION

PRIMARY DIAGNOSIS:

Patient's Gestational Age (GA) _____ Birth Weight _____ kg (lb)
 Current Weight _____ kg (lb) Date Recorded _____

Congenital Heart Disease (745.0-747.9) 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 week's 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) _____

MEDICAL CRITERIA:

- 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: _____
- 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: _____
- 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 RSV season, and clinically has the following risk factors (Check all that apply):
 School-age siblings Birth weight less than 2500 g
 Exposure to environmental air pollutants Crowded living conditions
 Day care Multiple birth
 Severe neuromuscular disease Family history of asthma
 Congenital abnormality of airway No other clinical risk factors

Other medical history: _____

NICU HISTORY:

- Did the patient spend time in the NICU? Yes No If yes, please attach the 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
EXPECTED DATE OF FIRST/NEXT INJECTION: _____ Injection already given? Yes, date(s): _____ No
 Deliver product to: Office Patient's Home Clinic Clinic Location: _____
 Agency nurse to visit home for injection? Yes No Agency Name: _____

Rx

Synagis® (palivizumab) 50- and/or 100-mg vials and Sterile Water for injection 10 mL (for lyophilized formulation only)*
 Sig: Reconstitute as directed and inject 15 mg/kg IM one time per month (for lyophilized formulation only) OR
 Sig: Inject 15 mg/kg IM one time per month (for liquid formulation only)
 Dispense Quantity: QS Refill _____ months
 Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed Known Allergies: _____
 Other _____
 Sig: _____
 Prescriber's Signature _____

*Synagis® liquid formulation will be automatically substituted upon manufacturers' market release.