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	Social Security Number	Sex M F
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 & 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)
Perceiver'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 COMPLETED FORM TO:

Attention: Prior Authorization Department
10680 Treena Street, Suite 500
Phone: 1-800-788-2949
Fax: 1-858-790-7100

L.A. Care HEALTH PLAN

4 CLINICAL INFORMATION

PRIMARY DIAGNOSIS:

PATIENT'S GESTATIONAL AGE (GA) ____________

CURRENT WEIGHT ____________ kg (lb) DATE RECORDED ____________

- ☐ Congenital Heart Disease (745.0 – 749.9)
- ☐ Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)
- ☐ ≤ 24 weeks' GA (765.21 – 765.22)
- ☐ 25 – 26 weeks' GA (765.23)
- ☐ 27 – 28 weeks' GA (765.24)
- ☐ Other Respiratory Conditions of Fetus and Newborn (770.0 – 770.9)
- ☐ 29 – 30 weeks GA (765.25)
- ☐ 31 – 32 weeks' GA (765.26)
- ☐ 33 – 34 weeks' GA (765.27)
- ☐ 35 – 36 weeks' GA (765.28)
- ☐ 37 or more weeks' GA (765.29)
- ☐ Congenital Anomalies of Respiratory system (748)
- ☐ Other ____________

Secondary Diagnosis (If applicable) ____________

MEDICAL CRITERIA:

1. Patient less than 24 months of age at the start of the RSV season with hemodynamically significant cyanotic or acyanotic Congenital Heart Disease (CHD), including one of the following: infants/children requiring medication to control congestive heart failure (CHF); infants/children with moderate to severe pulmonary hypertension; infants/children with cyanotic heart disease. (*Please call LA Care Pharmacy Department before giving Synagis to this sub group)* ☐ Yes ☐ No
(Maximum of 5 doses)

2. Patient less than 24 months of age at the start of the RSV season with Bronchopulmonary Dysplasia (BPD) *formerly known as Chronic Lung Disease (CLD)* that has required treatment (e.g., supplemental oxygen, bronchodilator, diuretic, or corticosteroid) within 6 months before the start of the RSV season. ☐ Yes ☐ No
(Maximum of 5 doses)

3. Patient without BPD who was born less than or equal to 28 weeks, 6 days gestational age and is less than 12 months of age at the start of RSV season. ☐ Yes ☐ No
(Maximum of 5 doses)

4. Patient without BPD who was born greater than or equal to 29 weeks, 0 days and less than or equal to 31 weeks, 6 days gestational age and is less than 6 months of age. ☐ Yes ☐ No
(Maximum of 5 doses)

5. Patient born greater than or equal to 32 weeks, 0 days and less than or equal to 34 weeks, 6 days gestational age with **one** of the following risk factors and is less than 3 months of age.
☐ Infant attends child care (*AAP Redbook recommends that childcare should be restricted for high risk children whenever feasible); or*
☐ *Siblings less than 5 years of age*
(Maximum of 3 doses) Some will receive only 1 or 2 doses before reaching 3 months (90 days) of age.

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 INJECTIONS: ____________ 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 1.0 mL (for lyophilized formulation only)

Sig: Reconstitute as directed and inject 15 mg/kg IM one time per month (for lyophilized formulation only) OR

Dispense quantity: QS Refill ____________times monthly

☐ **Epinephrine** 1:1000 amp. Sig: Inject 0.01 mg/kg as directed Known Allergies: ____________

Other: ____________

Sig: ____________

Prescriber's Signature: ____________