

STATEMENT OF MEDICAL NECESSITY

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

1 **Accredo Health Group, Inc.** **877 369-3447**
 Preferred Specialty Pharmacy FAX Number (+ Area Code)

2 **PATIENT INFORMATION**

Last Name First Name Middle Initial
 Street Address City
 County State ZIP Code
 M 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

3 **PHYSICIAN INFORMATION**

Prescriber's Name Hospital/Clinic Office Contact
 Address City/State/ZIP Telephone Number (+Area Code)
 Prescriber's Independent Health Provider # DEA Number Fax Number (+Area Code)
 Medicaid Provider Number UPIN Number NPI Number
 Supervising Physician's Name (If Required for Mid-Level Practitioner) Independent Health Provider Number

4 **PRESCRIBER CONSENT:** I acknowledge that I have assisted the patient in enrolling in the RSV Connection™ system exclusively for the purpose of patient care. I certify that I am prescribing the drug listed for the patient listed and I authorize RSV Connection™ to transmit this prescription form electronically, by facsimile or by mail to a dispensing pharmacy. I appoint RSV Connection™ as my agent to convey on my behalf to the pharmacy of patient's choice the prescription described herein. In addition, if agreed upon with the patient, I understand that the dispensing specialty pharmacy may send the medication to my office to deliver to the patient. I agree that I will not seek reimbursement for any medication provided hereunder from any government program or third party insurer. Prescriber's Signature (no stamps) _____
 Name (print) _____ Date _____

5 **CLINICAL INFORMATION**

PRIMARY DIAGNOSIS: Patient's Gestational Age (GA) _____ Birth Weight kg lbs
 Current Weight _____ kg lbs 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:

1. 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: _____

2. Diagnosis of hemodynamically significant congenital heart disease (CHD) and less than 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

3. 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):

Yes No School-age siblings Yes No Birth weight <2500 g
 Yes No Daycare attendance Yes No Crowded living conditions
 Yes No Exposure to environmental air pollutants Yes No Multiple birth
 Yes No Severe neuromuscular disease Yes No Family history of asthma
 Yes No Congenital abnormality of airway Yes No Distance to healthcare provider
 Yes No Exposure to environmental tobacco smoke Yes No None

Other medical history/medications: _____

NICU HISTORY:

Did patient spend time in the NICU or Special Care Nursery? 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
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
 Sig: Inject 15 mg/kg IM one time per month (every 28-30 days) Dispense Quantity: QS up to 90 ds Refill: _____
 Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed Known Allergies: _____

Prescriber's Signature (sign one of two lines below) _____ Date: _____

 Dispense as Written Substitution Allowed
 Signature required. No Stamps. Prescriber certifies this is his/her full and usual signature.

Supervising Physician's Signature: _____
 Interchange is mandated unless the Practitioner writes the words "no substitution" in this space.