

**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 <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth	Social Security Number	Sex
Parent/Guardian		

**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 \_\_\_\_\_

SYN-00001-082509

**5** **CLINICAL INFORMATION**

**PRIMARY DIAGNOSIS:** Patient's Gestational Age (GA) \_\_\_\_\_ Birth Weight  kg  lbs  
 Current Weight \_\_\_\_\_  kg  lbs Date Recorded: \_\_\_\_\_

<input type="checkbox"/> Congenital Heart Disease (745.0-747.9)	<input type="checkbox"/> 29-30 weeks' GA (765.25)
<input type="checkbox"/> Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)	<input type="checkbox"/> 31-32 weeks' GA (765.26)
<input type="checkbox"/> ≤24 weeks' GA (765.21-765.22)	<input type="checkbox"/> 33-34 weeks' GA (765.27)
<input type="checkbox"/> 25-26 weeks' GA (765.23)	<input type="checkbox"/> 35-36 weeks' GA (765.28)
<input type="checkbox"/> 27-28 weeks' GA (765.24)	<input type="checkbox"/> 37 or more week's GA (765.29)
<input type="checkbox"/> Other Respiratory Conditions of Fetus and Newborn (770.0-770.9)	<input type="checkbox"/> Congenital Anomalies of Respiratory System (748)
<input type="checkbox"/> 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 (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
- 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 has the following risk factors (Check all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> School-age siblings                      | <input type="checkbox"/> Birth weight <2500 g                |
| <input type="checkbox"/> Daycare attendance                       | <input type="checkbox"/> Crowded living conditions           |
| <input type="checkbox"/> Exposure to environmental air pollutants | <input type="checkbox"/> Multiple birth                      |
| <input type="checkbox"/> Severe neuromuscular disease             | <input type="checkbox"/> Family history of asthma            |
| <input type="checkbox"/> Congenital abnormality of airway         | <input type="checkbox"/> Young chronological age (≤12 weeks) |
| <input type="checkbox"/> Exposure to environmental tobacco smoke  | <input type="checkbox"/> Residency in rural setting          |

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)  
 Sig: Inject 15 mg/kg IM one time per month (every 28-30 days) Dispense Quantity: QS up to 90 day supply 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.