SYNAGIS® PALIVIZUMAB

STATEMENT OF MEDICAL NECESSITY

RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS

Complete form in its entirety and fax to number listed below

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KING DRUG AND HOME CARE

COVENTRYCARES™ of Kentucky
Lighting Your Path to Good Health

Supplier Questions? Contact:
IV Department
Phone: 800-489-2609
Fax: 270-843-7477
IVCoordinator@kingdrug.com
Richard Hayden, Pharm.D.

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PATIENT INFORMATION

Last Name | First Name | Middle Initial

Street Address | City | State | Zip Code

Day Telephone (+Area Code) | Night Telephone (+Area Code) | ☐ M ☐ 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 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

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CLINICAL INFORMATION

PRIMARY DIAGNOSIS

Patient's Gestational Age:_____ Birth Weight_____ kg/lbs

Current Weight_____ Date Recorded_____

☐ Congenital Heart Disease (747.0-745.4)
☐ Chronic Lung Disease (CLD) (770.7)
☐ ≥24 weeks of gestation (765.21-765.22)
☐ 25-26 weeks of gestation (765.23)
☐ 27-28 weeks of gestation (765.24)
☐ Congenital Abnormality of Respiratory System (770.0-770.9)
☐ Other_____

☐ 29-30 weeks of gestation (765.25)
☐ 31-32 weeks of gestation (765.26)
☐ 33-34 weeks of gestation (765.27)
☐ 35-36 weeks of gestation (765.28)
☐ 37 weeks of gestation (765.29)
☐ Other Respiratory Conditions of Fetus and Newborn

Secondary diagnosis (if applicable)_____

MEDICAL CRITERIA: (please attach medical notes as support)

1. 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:_____

2. Diagnosis of hemodynamically significant congenital heart disease and <24 months of age? ☐ Yes ☐ No
   Patient has the following condition: ☐ Diagnosis of moderate-severe pulmonary hypertension
   ☐ Medications for 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 weeks, one day - 35 weeks and <6 months at the start of RSV season

Clinically has the following risk factors (Check all that apply)
☐ School-age siblings
☐ Day care attendance
☐ Birth weight less than 2500 grams
☐ Severe neuromuscular disease
☐ Congenital abnormality of airway
☐ Exposure to environmental air pollutants*
specify pollutant: _____

Other medical history: _____

*Red Book 2003; AAP identifies exposure to tobacco smoke as a family controlled risk factor and will not be accepted as a primary risk factor

NICU HISTORY: ☐ Yes ☐ No Please attach the NICU Discharge Summary
Was there a NICU/HOSPITAL dose administered? ☐ Yes ☐ No Date(s):_____
EXPECTED DATE OF FIRST/NEXT INJECTION:_____ Injection already given? ☐ Yes Date(s):_____ ☐ No
Deliver product to: ☐ Office ☐ Patient's Home ☐ HHC ☐ Clinic HHC/Clinic Location_____
Agency Nurse to visit home for injection: ☐ Yes ☐ No

Rx

☐ **Synagis® (palivizumab)** 50 and/or 100 mg vials (include Sterile Water for Injection if provided in lypholized formulation).
Sig: Reconstitute as directed and inject 15 mg/kg IM one time per month (for lypholized formulation only)
Sig: Inject 15mg/kg IM one time per month (for liquid formulation only)
Dispense Quantity: QS for weight based dosing Approval, if given, is for 5 doses given once monthly: ☐
☐ **Epinephrine** 1:1000 amp. Sig: Inject 0.01 mg/kg as directed ☐ Known Allergies:_____
☐ Other_____
Sig:_____
Prescriber's Signature_____
Supervising Physician's Signature_____ **Date**_____

***Completion of this form is not a guarantee of approval. Eligibility verification is the responsibility of the provider.

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