



Date: \_\_\_\_\_ Date Medication Required: \_\_\_\_\_
Ship to:  Physician  Patient's Home  Other \_\_\_\_\_

Phone: 866-399-0928 Fax: 877-386-4695

Patient Information

Last Name: First Name: Middle: DOB: \_\_\_/\_\_\_/\_\_\_
Address: City: State: Zip:
Daytime Phone: Evening Phone: Sex:  Male  Female

Insurance Information (Attach copies of cards)

Primary Insurance: Secondary Insurance:
ID # Group # ID # Group #
City: State: City: State:

Physician Information

Name: Specialty: NPI:
Address: City: State: Zip:
Phone #: Secure Fax #: Office Contact:

Primary Diagnosis

ICD-10 Code: \_\_\_\_\_
 Preterm birth  Chronic lung disease of prematurity (bronchopulmonary dysplasia)  Congenital heart disease
 Anatomic pulmonary abnormalities  Neuromuscular disorder  Profoundly immunocompromised  Cystic fibrosis
 Other: \_\_\_\_\_

Prescription Information

Table with 5 columns: MEDICATION, STRENGTH, DIRECTIONS, QUANTITY, REFILLS. Row 1: Synagis (palivizumab)

Clinical Information

\*\*\*\*\* Please submit supporting clinical documentation \*\*\*\*\*

INITIAL THERAPY  CONTINUATION OF THERAPY; Therapy start date: \_\_\_\_\_

- 1. Has patient had a positive response to the prescribed therapy?  Yes: \_\_\_\_\_  No  Not applicable
2. Is Synagis prescribed for prophylaxis of respiratory syncytial virus (RSV)?  Yes  No
3. Has patient received more than 5 doses of Synagis during the current RSV season?  Yes: \_\_\_ doses  No
a. If yes, did patient undergo cardio-pulmonary bypass during the current RSV season?  Yes  No
4. If requests for RSV prophylaxis extend beyond the identified season duration for Florida or beyond September through May for the remainder of the U.S., is there medical justification supporting use?  Yes \*\*Submit documentation\*\*  No
5. Has patient been hospitalized with RSV disease during the current RSV season?  Yes  No
6. Please document patient's current weight: \_\_\_\_\_ kg

Complete this section ONLY if the patient is initiating therapy:

- 7. Is patient an Alaska native or American Indian?  Yes  No
8. Will patient be profoundly immunocompromised during the RSV season (e.g., due to solid organ or hematopoietic stem cell transplantation, chemotherapy, severe combined immunodeficiency, chronic granulomatous disease)?  Yes  No
9. If preterm birth or chronic lung disease of prematurity, please document patient's gestational age: \_\_\_\_\_ weeks \_\_\_\_\_ days
10. If chronic lung disease of prematurity,
a. Did patient require > 21% oxygen for at least 28 days after birth?  Yes  No
b. Has patient required any of the following within 6 months of the start of RSV season?  Yes \*\*Mark all that apply\*\*  No
 Supplemental oxygen  Chronic systemic corticosteroid therapy  Diuretic therapy

Please continue to page 2.



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11. If congenital heart disease, does any of the following apply to patient?  Yes **\*\*Mark all that apply\*\***  No

- Acyanotic heart disease
- Cyanotic heart defect and RSV prophylaxis is recommended by pediatric cardiologist
- Medication to control congestive heart failure required
- Cardiac surgical procedure required
- Moderate to severe pulmonary hypertension
- Undergoing cardiac transplantation or cardio-pulmonary bypass during the current RSV season

12. If anatomic pulmonary abnormalities or neuromuscular disorder, does patient have impaired ability to clear secretions from the upper airways (e.g., due to ineffective cough)?  Yes  No

13. If cystic fibrosis,

- a. Does patient have manifestations of severe lung disease (e.g., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable)?  Yes  No
- b. Is patient's weight for length < 10<sup>th</sup> percentile?  Yes  No
- c. Is there clinical evidence of nutritional compromise?  Yes  No
- d. Has patient been diagnosed with chronic lung disease of prematurity?  Yes  No

Complete this section ONLY for indications other than those listed above:

14. Has patient tried and failed, or is contraindicated to, accepted standards of care?  Yes  No

**\*\*If yes, submit documentation and answer the following:\*\***

- a. Please list all previous therapies: \_\_\_\_\_
- b. Was patient adherent to previously tried therapies?  Yes  No  No, patient intolerant to drug

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_  DAW