



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
Patient's Mother's Name and DOB:

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:

Home Healthcare Agency Name and Contact Information (if applicable):

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

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

Patient Name: _____ DOB: _____

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 < 10th 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