SYNAGIS® PALIVIZUMAB

Wilcox Home Infusion Respiratory Syncytial Virus (RSV) Prophylaxis
STATEMENT OF MEDICAL NECESSITY RSV Season 2008-2009
Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name	First Name			Middle Initial
Street Address	City	State	County	Zip Code ☐M ☐F
Date of Birth	Social Security Number			Gender
	( )		( )	
Parent/Guardian	Day Telephone		Night Telephone	
Emergency Contact	Relationship		Telephone	

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 & SSN (if not patient)	Cardholder Name & SSN (if not patient)
Group Number	Group Number
Policy Number	Policy Number
( )	( )
Insurance Telephone Number	Insurance Telephone Number
Employer	

2 PHYSICIAN INFORMATION

Prescriber's Name	Hospital/Clinic	Office Contact
Address	City/State/Zip	Telephone Number
Prescriber's License Number	UPIN Number	NPI Number
Supervising Physician's Name (If Required for Mid-Level Practitioner)		License Number

Wilcox MEDICAL

Wilcox Home Infusion
250 Stratton Road
Rutland, Vermont 05701

Fax Completed Form to:
Fax Number: 802-775-7824
Phone Number: 800-639-1210

CHS Critical Homecare Solutions, Inc. Growing a Family of Services

3 VERMONT

Office of Vermont Health Access
SYNAGIS® (PALIVIZUMAB) PRIOR AUTHORIZATION REQUEST

weeks: days:	kg:	15mg/kg=	mg
Gestational Age	Current Weight	Dose	
	Wilcox Home Infusion	800-639-1210	802-775-7824
Diagnosis	Pharmacy	Phone	Fax

☐ Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under 12 months of age at the start of the RSV season.

☐ Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 32 weeks, 0 days) of gestation and under 6 months of age at the start of the RSV season.

☐ Infants born at 32-35 weeks (i.e., between 32 weeks, 1 day and 35 weeks, 0 days) of gestation and under 6 months of age at the start of the RSV season (November 1) who have **two** of the following risk factors:
- ☐ Child care attendance ☐ School-aged siblings
- ☐ Congenital abnormalities of the airways ☐ Severe Neuromuscular Disease
- ☐ Exposure to environmental air pollutants (e.g. exposure to wood burning heaters which are the primary source of heat for the family or passive household exposure to tobacco smoke)

☐ Children under 24 months of age with chronic lung disease of prematurity (bronchopulmonary dysplasia) who have received medical therapy (supplemental oxygen, bronchodilator, diuretic or corticosteroid therapy) within 6 months prior to the start of the RSV season.
☐ Treatment: ☐ Dates of Use:

☐ Children under 24 months of age with hemodynamically significant cyanotic or acyanotic heart disease:
- ☐ Currently receiving medication to control heart failure
- ☐ Having moderate to severe pulmonary hypertension
- ☐ Having cyanotic heart disease

☐ Other:

NICU HISTORY

Did the patient spend time in the NICU?
☐ Yes ☐ No (If yes, please attach the NICU summary)
Was RSV prophylaxis recommended by the NICU/Hospital physician for this patient?
☐ Yes ☐ No
Was a NICU/Hospital /Clinic dose administered?
☐ Yes, Date(s): ☐ No

PRESCRIPTION and ORDERS

Synagis (palivizumab) 50 and/or 100 mg vials and supplies for administration.
Sig: Inject 15 mg/kg IM once every 4 weeks; expected date of first home injection:_____
Dispense Quantity: Quantity sufficient for prophylaxis thru 04/09
Known Allergies:_____
Deliver product to: ☐ MD office ☐ Patient's home ☐ Clinic
☐ Home health nurse to administer injection Home Health Agency:_____
If delivery is to clinic, please give location:_____
Pediatric Anaphylaxis: Administer 0.01 ml/kg (max 0.3ml) of 1:1000 epinephrine solution subcutaneously or intramuscularly, and contact EMS or physician, as appropriate.
Other:_____
Sig: _____
Physician will monitor patient's response to therapy. Any complications in therapy will be reported to the physician either by the patient's caregiver, or the skilled nursing service (If other than physician's office or Wilcox Home Infusion)

Prescriber's Signature: _____ **Date:** _____
Supervising Physician's Signature: _____
This order is valid for the entire upcoming season if signed prior to the November dose, or for the remainder of the present season if signed after November.