Cincinnati Children's
Home Care Services

STATEMENT OF MEDICAL NECESSITY
RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS

SYNAGIS® PALIVIZUMAB

MR #: _____ Account #: _____

L1110
HIC 01/08

1 PATIENT INFORMATION

Last Name | First Name | Middle Initial

Street Address | City

County | State | Zip Code

☐ M ☐ F

Date of Birth | Social Security Number | Sex

Primary Guardian | Secondary Guardian

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

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 | Independent Physician Association

2 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 | NPI Number | UPIN Number

Supervising Physician's Name (If Required for Mid-Level Practitioner) | License Number

FAX COMPLETED FORM TO: 513-636-3951

DTL1110

3 CLINICAL INFORMATION

Primary Diagnosis:

PATIENT'S GESTATIONAL AGE (GA): _____ BIRTH WEIGHT: _____

CURRENT WEIGHT _____ ☐ kg ☐ lb DATE RECORDED_____

☐ Congenital Heart Disease (745.0-747.9)
☐ Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)
☐ ≤24 weeks' GA (765.21-765.22)
☐ 25-26 weeks' GA (765.23)
☐ 27-28 weeks' GA (765.24)
☐ Other Respiratory Conditions of Fetus and Newborn (770.0-770.9)
☐ Spinal Muscular Atrophy (335.10)
☐ Other _____
☐ 29-30 weeks' GA (765.25)
☐ 31-32 weeks' GA (765.26)
☐ 33-34 weeks' GA (765.27)
☐ 35-36 weeks' GA (765.28)
☐ 37 or more weeks' GA (765.29)
☐ Congenital Anomalies of Respirator System (748)

Secondary Diagnosis (if applicable) _____

MEDICAL CRITERIA:

1. Prematurity: ☐ GA of ≤28 weeks and <12 months of age at the start of RSV season
2. Prematurity: ☐ GA of 29-32 weeks and <6 months of age at the start of RSV season
3. Prematurity: ☐ GA of 33-35 weeks and <6 months at the start of RSV season and with the following risk factors (check all that apply):

☐ Yes ☐ No	School-age siblings	☐ Yes ☐ No	Birth weight <2500 g
☐ Yes ☐ No	Daycare attendance	☐ Yes ☐ No	Crowded living conditions
☐ Yes ☐ No	Exposure to environmental air pollutants	☐ Yes ☐ No	Multiple birth
☐ Yes ☐ No	Severe neuromuscular disease	☐ Yes ☐ No	Family history of asthma
☐ Yes ☐ No	Congenital abnormality of airway	☐ Yes ☐ No	Distance to healthcare provider
☐ Yes ☐ No	Exposure to environmental tobacco smoke	☐ Yes ☐ No	Young chronologic age ≤12 weeks

☐ None

Other medical history:_____

4. Diagnosis of chronic pulmonary disease (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:_____
5. 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

NICU/HOSPITAL HISTORY:

Did the patient spend time in the NICU or Special Care Nursery? ☐ Yes ☐ No
If yes, please attach the Discharge Summary

Was there a previous dose administered? ☐ 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:_____ Agency Phone:_____

Signature/Credentials_____ Date_____