

## Cincinnati Children's STATEMENT OF MEDICAL NECESSITY Synagis® RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS

L<sub>1110</sub> HIC 10/11

ne Care Services	MR #: Account :	#:
,	PATIENT INFORMATION	
Last Name	First Name	Middle Initial
Street Address		City
County	State	Zip Code □ M □ F
Date of Birth		Sex
Primary Guardian	Secondary Guardian	
Day Telephone (Area Code) Nig	ght Telephone (Area Code) Cell Num	ber (Area Code)
	SURANCE INFORMATION cards and drug benefit cards (front and back) to	expedite benefit clearance.
Primary Insurance	Secondary Insurance	
Cardholder Name & Social Security Numb	er (If Not Patient) Cardholder Name & Social	Security Number (If Not Patient)
Group Number	Group Number	
Policy Number	Policy Number	
Insurance Telephone Number (+Area Code	e) Insurance Telephone Numb	per (+Area Code)
Employer	Independent Physician Ass	ociation
<b>2</b>	PHYSICIAN INFORMATION	
Prescriber's Name	Clinic/Office	Office Contact
Address	City/State/ZIP	
Prescriber's DEA Number	Prescriber's NPI Number	
Telephone Number (+Area Code)		
Fax Number (+Area Code)		
F.	AX COMPLETED FORM TO:	

513-636-3951

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É	CLINICAL INFORMATION		
	Primary Diagnosis:		
	PATIENT'S ĞESTATIONAL AGE (GA): BIRTH WEIGHT: CURRENT WEIGHT: □ kg □ lb DATE RECORDED:		
1	<ul> <li>□ Congenital Heart Disease (745.0-747.9)</li> <li>□ 29-30 weeks GA (765.25)</li> <li>□ Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)</li> <li>□ 31 - 32 weeks, GA (765.26)</li> </ul>		
	□ ≤24 weeks GA (765.21-765.22) □ 33-34 weeks GA (765.27)		
1	□ 25-26 weeks GA (765.23) □ 35-36 weeks GA (765.28) □ 27-28 weeks GA (765.24) □ 37 or more weeks GA (765.29)		
	☐ Other Respiratory Conditions of Fetus and Newborn (770.0-770.9) ☐ Spinal Muscular Atrophy (335.10)		
-	Congenital Anomalies of Respiratory System (748)     Other     Congenital Anomalies of Respiratory System (748)		
	□ Other Secondary Diagnosis (if applicable)		
-	MEDICAL CRITERIA:		
	PLEASE SUBMIT A LETTER OF MEDICAL NECESSITY IF THE CHILD DOES NOT MEET THE FOLLOWING CRITERIA:		
1	□ Diagnosis of Chronic Lung Disease (formally called bronchopulmonary dysplasia) AND		
_	Child must be < 24 mos. of age at onset of season on Nov. 1st AND required medical treatment in the preceding 6 months. Check all therapies that may apply:		
	Oxygen Most recent date administered		
-	□ Oxygen Most recent date administered □ Corticosteroids Most recent date administered		
	<ul> <li>□ Bronchodilators Most recent date administered</li> <li>□ Diuretics Most recent date administered</li> </ul>		
	Hemodynamically significant cyanotic or acyanotic congenital hear t disease, (CHD) AND Child must be < 24 mos. of age at onset of season on Nov. 1st		
	☐ Congestive Heart Failure or Cardiomyopathy: Meds:		
	☐ Moderate to severe Pulmonary Hypertension: Meds:		
-	☐ Cyanotic heart disease: Meds:		
	☐ Child is ≤ 12 months of age on Nov. 1st AND☐ Gestational age ≤ 28 weeks, 6 days, OR		
-	☐ Gestational age ≤ 34 weeks, 6 days AND		
	<ul> <li>Congenital abnormalities of the airway OR</li> <li>Neuromuscular condition requiring handling of respiratory secretions</li> </ul>		
1	Neuromuscular containon requiring flantaling of respiratory secretions		
-	☐ Child is ≤ 6 months of age on Nov. 1st AND gestational age is 29 weeks, 0 days through 31 weeks,		
╛	6 days.		
1	☐ Child is ≤ 3 months of age on Nov 1st AND gestational age is 32 weeks, 0 days through 34 weeks,		
	6 days, AND  ☐ Child has a sibling ≤ 5 years of age OR		
┨	☐ Child attends daycare, defined as a home or facility where care is provided for any number of		
	infants or young toddlers  CHILDREN IN THIS CATEGORY WILL QUALIFY FOR MONTHLY DOSES UP TO 3 MONTHS OF AGE.		
1	CHILDREN IN THIS CATEGORY WILL GOALIFT FOR MONTHET DOGES OF TO 3 MONTHS OF AGE.		
4	NICU/HOSPITAL HISTORY:		
	Did the patient spend time in the NICU or Special Care Nursery?  Yes  No		
1	If yes, please attach the Discharge Summary		
$\frac{1}{2}$	Was there a previous dose administered? ☐ Yes Date(s): ☐ No Deliver product to: ☐ Office ☐ Patient's Home ☐ Clinic - Location:		
	Agency nurse to visit home for injection: ☐ Yes ☐ No Agency Name:		
1	Agency Phone:		
	Signature/Credentials Date		