



**STATEMENT OF MEDICAL NECESSITY**  
 RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS  
 FAX COMPLETED FORM TO RSV CONNECTION™ AT: 1-866-252-1749  
 FOR QUESTIONS, CONTACT RSV CONNECTION™ AT: 1-877-RSV-9010 (1-877-778-9010)

**1 Maxor/IVSolutions** **1-866-217-8034**  
 Preferred Specialty Pharmacy Fax number (+ area code)  
**1-866-629-6779**  
 Phone number (+ area code)

**2 PATIENT INFORMATION**

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle initial \_\_\_\_\_  
 Street address \_\_\_\_\_ City \_\_\_\_\_  
 County \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Social Security number \_\_\_\_\_ Sex  M  F  
 Primary guardian \_\_\_\_\_ Secondary guardian \_\_\_\_\_  
 Day telephone (+ area code) \_\_\_\_\_ Night telephone (+ area code) \_\_\_\_\_  
 Patient one of multiple births? Yes  No   
 If yes, is sibling(s)' referral being submitted simultaneously? Yes  No   
 Sibling name(s) \_\_\_\_\_

**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) \_\_\_\_\_  
 Policy number \_\_\_\_\_ Policy number \_\_\_\_\_  
 Group number \_\_\_\_\_ Group number \_\_\_\_\_  
 Insurance telephone number (+ area code) \_\_\_\_\_ Insurance telephone number (+ area code) \_\_\_\_\_

Employer \_\_\_\_\_ IPA \_\_\_\_\_

**3 PHYSICIAN INFORMATION**

Prescriber's name \_\_\_\_\_ Site name \_\_\_\_\_ Office contact \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/ZIP \_\_\_\_\_ Telephone number (+ area code) \_\_\_\_\_  
 Prescriber's license number \_\_\_\_\_ DEA number \_\_\_\_\_ Fax number (+ area code) \_\_\_\_\_  
 Medicaid provider number \_\_\_\_\_ Tax ID number \_\_\_\_\_ NPI number \_\_\_\_\_  
 Supervising physician's name (if required for mid-level practitioner) \_\_\_\_\_ License number \_\_\_\_\_

**4 CLINICAL INFORMATION**

**PRIMARY DIAGNOSIS:**  
 PATIENT'S GESTATIONAL AGE (GA) \_\_\_\_\_ BIRTH WEIGHT \_\_\_\_\_ kg or \_\_\_\_\_ lb  
 CURRENT WEIGHT \_\_\_\_\_ kg or \_\_\_\_\_ lb DATE CURRENT WEIGHT RECORDED \_\_\_\_\_

Congenital heart disease (745.0-747.9)  29-30 weeks' GA (765.25)  
 Chronic respiratory disease arising in the perinatal period (CRD) (770.7)  31-32 weeks' GA (765.26)  
 ≤24 weeks' GA (765.21-765.22)  33-34 weeks' GA (765.27)  
 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)  Congenital anomalies of respiratory system (748)  
 Other \_\_\_\_\_ Secondary diagnosis (if applicable) \_\_\_\_\_

**MEDICAL CRITERIA:**

1. Diagnosis of chronic lung disease/bronchopulmonary disease (CLD/BPD) and less than 24 months of age?   
 Is patient receiving medical treatment of (check all that apply and provide last date received):  Oxygen date: \_\_\_\_\_  
 Corticosteroids date: \_\_\_\_\_  Bronchodilator date: \_\_\_\_\_  Diuretics date: \_\_\_\_\_

2. Diagnosis of hemodynamically significant congenital heart disease (CHD) and ≤24 months of age?   
 Patient has the following condition:  
 Medications for CHD: \_\_\_\_\_ Last date received: \_\_\_\_\_  
 Diagnosis of moderate to severe pulmonary hypertension  Cyanotic CHD

3. Has the following risk factors (check all that apply):  
 School-aged siblings  Young chronological age (≤12 weeks)  
 Daycare attendance  Crowded living conditions  
 Exposure to environmental air pollutants  Exposure to environmental tobacco smoke  
 Severe neuromuscular disease  Birth weight <2500 g  
 Congenital abnormality of airways  Multiple births  
 None  Family history of asthma or wheezing  
 Residency in rural setting

Other medical history: \_\_\_\_\_

**HOSPITAL HISTORY:**

Did the patient spend time in the NICU/PICU/special care nursery?  Yes  No  
 If yes, please attach the discharge summary.  
 Was RSV prophylaxis recommended by the hospital physicians for this patient?  Yes  No  
 Was a Synagis dose administered in the NICU/hospital?  Yes date(s): \_\_\_\_\_  No

EXPECTED DATE OF FIRST/NEXT INJECTION: \_\_\_\_\_ Injection already given?  Yes date(s): \_\_\_\_\_  No  
 Please complete month and day to indicate if next dose is to be given during current or next RSV season.

Deliver product to:  Office  Patient's home  Clinic Clinic location: \_\_\_\_\_  
 Agency nurse to visit home for injection?  Yes  No Agency name: \_\_\_\_\_

**Rx** Please check appropriate product(s):  
 Synagis® (palivizumab) 50 mg and/or 100 mg vials  
 Sig: Inject 15 mg/kg IM one time per month (every 28-30 days).  
 Dispense quantity: QS Refill monthly: \_\_\_\_\_ months  
 Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg SC as directed  Known allergies: \_\_\_\_\_

I hereby grant the RSV Connection program limited agency to convey on my behalf to the pharmacy chosen by or for the above-named patient, the prescription described herein.

Prescriber's signature \_\_\_\_\_ Date \_\_\_\_\_  
 Signature and date must be provided.