



**2010-2011 SYNAGIS MEDICAL NECESSITY FORM
RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS**

Complete form in its entirety and fax to
St. John's Health Plans @ 417-820-6318 or 800-863-8040

PATIENT INFORMATION

Last Name	First Name	Middle Initial <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth	Social Security Number	Sex
Parent/Guardian	County	
Address	City/State	ZIP Code
Phone: Home	Work	Cell
Additional Contact Person		Phone

INSURANCE INFORMATION

Primary Insurance	Policy #
Cardholder Name & Social Security Number (If Not Patient)	Group #
Employer	Insurance Telephone Number (+ area code)
Secondary Insurance	Policy Number
Cardholder Name & Social Security Number (If Not Patient)	Group #
Employer	Insurance Telephone Number (+ area code)

OFFICE USE ONLY

Authorization: Approved Denied Authorization Number: _____
 Previous Synagis Prophylaxis Dates: 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___
 Check acceptable locations of service: Any Office Home Health Outpatient

2 PEDIATRICIAN/PHYSICIAN INFORMATION

Attending Physician 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	License #

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Place Patient ID Label Here
(if applicable)

NEWBORN INFORMATION

PRIMARY DIAGNOSIS:

Patient's Gestational Age (GA) _____ Birth Weight _____ kg (lb)
 Current Weight _____ kg (lb) Date Recorded _____

Congenital Heart Disease (745.0-747.9) 27-28 weeks' GA (765.24)
 Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7) 29-30 weeks' GA (765.25)
 ≤24 weeks' GA (765.21-765.22) 31-32 weeks' GA (765.26)
 25-26 weeks' GA (765.23) 33-34 weeks' GA (765.27)
 Other Respiratory Conditions of Fetus and Newborn (770.0-770.9)
 Congenital Anomalies of Respiratory System (748)
 Other _____ Secondary diagnosis (if applicable) _____

NICU HISTORY:

Did the patient spend time in the NICU? Yes No If yes, please attach the NICU Discharge Summary
 Was RSV prophylaxis recommended by the NICU/HOSPITAL physicians for this patient? Yes No
 Was there a NICU/HOSPITAL dose administered? Yes Date(s): _____ No
EXPECTED DATE OF FIRST/NEXT INJECTION: _____ Injection already given? Yes Date(s): _____ No
NICU/Referral Physician (printed name): _____
NICU/Referral Physician Signature: _____ Date: _____

MEDICAL CRITERIA (Check all that apply):

- Diagnosis of chronic pulmonary disease (CLD/BPD) and ≤24 months of age (DOB 11/1/2008 or later) and has received medical therapy for CLD within 6 months of RSV season? 5 doses maximum recommended* (**Send Records**)
- Diagnosis of hemodynamically significant congenital heart disease and ≤24 months of age (DOB 11/1/2008 or later)? 5 doses maximum recommended* (**Send Records**)
- Gestational age of ≤34 weeks 6 days and congenital abnormality of the airway or neuromuscular disease compromising handling of respiratory secretions; maximum of 5 doses recommended during the first year of life* (**Send Records**)
- Gestational age of ≤28 weeks 6 days and ≤1 year of age (DOB 11/1/2009 or later); 5 doses maximum recommended*
- Gestational age of 29 - 31 weeks 6 days and <6 months of age (DOB 5/1/10 or later)? 5 doses maximum recommended*
- Gestational age of 32- 34 weeks 6 days and <3 months of age (DOB after 8/1/10), having ONE of the following required risk factors, and receive prophylaxis until the infant reaches three months of age; 3 doses maximum recommended*
 (Check all that apply):
 Siblings < 5 years of age Infant attends childcare
- Other Diagnosis: _____

RX: Synagis® (palivizumab) 50- and/or 100-mg vials

Sig: Inject 15 mg/kg IM one time per month (for liquid formulation only)
 Dispense Quantity: _____
 Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed Known Allergies: _____
 Other _____
 Sig: _____

Attending Physician Signature: _____ **Date:** _____

*Current AAP recommendations. Continued monthly injections during the RSV season can be authorized if attending physician feels additional dosages are necessary based on clinical experience and concerns.