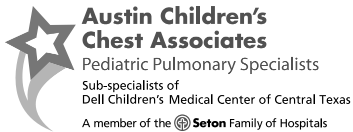

STATEMENT OF MEDICAL NECESSITY

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 TREATING PHYSICIAN OFFICE

AUSTIN CHILDREN'S CHEST ASSOCIATES
3305 Northland Dr., Ste 512
Austin, TX 78731

Office Contact: Sandi Anderson or Elizabeth Eakin
Phone: 512-380-9200 ext. 115 or 112

Tax ID: 26-0163261

	License#	NPI#	MCD#
Dr. McWilliams	F1812	1689746935	164225801
Dr. Scalo	L5550	10130899218	164225801
Dr. Fullmer	L0800	1184796401	164225801

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 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 REFERRING PHYSICIAN OFFICE

Physician Name ______ Office ______

Contact ______

Address ______ City/ State/Zip code ______

Telephone ______ Fax ______

4 GENERAL INFORMATION

PRIMARY DIAGNOSIS

PATIENT'S GESTATIONAL AGE (GA) ______ BIRTHWEIGHT ______ kg or ______ lb
CURRENT WEIGHT ______ kg or ______ lb DATE CURRENT WEIGHT RECORDED ______

☐ Congenital heart disease (745.0-747.9)
☐ Chronic respiratory disease arising in the perinatal period (CRD) (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)
☐ 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 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
   ☐ Daycare attendance
   ☐ Exposure to tobacco smoke
   ☐ Severe neuromuscular disease
   ☐ Congenital abnormality of airway
   ☐ None

   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.

FOR OFFICE USE ONLY

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.