2023-2024 SYNAGIS REFERRAL FORM

Telephone: 614-355-1100 Fax: 614-355-1182

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Section 1: Patient Information

Patient name (Last, First): _____ MRN_____ Sex (circle one) ☐M / ☐F

DOB: _____ Parent name(s) _____

Address: _____ City: _____ State: _____ Zip code: _____

Primary phone: _____ Secondary phone: _____ County: _____

Does patient have sibling that will be prescribed Synagis this season? ☐ Yes ☐ No Sibling name(s) _____

Section 2: Health Insurance Information

☐ No Insurance ☐ Completed ODJFS prior authorization form attached

Primary Insurance: _____ Secondary Insurance: _____

Policy ID Number: _____ Policy ID Number: _____

Subscriber Name: _____ Subscriber Name: _____

Section 3: Statement of Medical Necessity / Diagnosis Information

Patient's gestational age at birth: _____ Current weight: _____kg Date current weight recorded: _____

Diagnosis and Patient History (check all that apply)

☐ **Gestational age of ≤ 28 weeks and 6 days & < 12 months of age at start of RSV season (born on or after 11/1/22)**

☐ **Chronic lung disease of prematurity (CLDP)- ICD-10 code: _____**

a. Patient's gestational age is ≤ 31 weeks and 6 days? ○ Yes ○ No

b. Patient required > 21% oxygen for at least the first 28 days after birth? ○ Yes ○ No

c. Patient is receiving medical treatment? (check all that apply below and provide dates) ○ Yes ○ No

☐ Oxygen (dates _____) ☐ Corticosteroids (dates_____)

☐ Diuretics (dates _____) ☐ Bronchodilator (dates_____)

☐ **Hemodynamically significant congenital heart disease (CHD)- ICD-10 code: _____**

☐ Severe pulmonary hypertension

☐ Cyanotic heart defects and consultation with cardiologist

☐ Acyanotic heart disease and receiving medication to control CHF and will require cardiac surgical procedure

☐ **Other- ICD-10 code: _____**

☐ Neuromuscular disorder or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough

☐ Immunocompromised due to chemotherapy or other conditions

☐ Cystic Fibrosis with clinical evidence of CLD and/or nutritional compromise

Section 4: Ordering Information (must be signed by physician only)

Was 1st dose of season received in hospital/NICU/other location? ☐ Y ☐ N If so, date(s) received: _____

Pharmacy Order:

☐ Synagis (palivizumab) 15mg/kg IM every 28-31 days through 4/30/24 (unless insurance dictates otherwise) ☐ Epinephrine 1:1000 (1 mg/ml) ampule Disp #1. Sig: Inject 0.01 mg/kg IM prn anaphylaxis
(Respectfully requested for all Synagis patients)

☐ No Known allergies **or** List allergies: _____

Nursing Order: Homecare to administer Synagis dose of 15mg/kg IM every 28-31 days & weight to be determined at time of visit

☐ Date of 1st injection to be given between _____and_____ or ☐ ASAP

☐ If 1st injection given inpatient or in another setting, subsequent injection to be given every 28-31 days of previous injection date x4-6 months

☐ No nursing required

Practitioner (or) APN (or) PA signature: _____ Date/Time: _____

Practitioner name**:** _____ NPI #: _____ Practice name: _____

Office address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Office contact: _____

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY
FOR HOME HEALTH SERVICES AND PRIVATE DUTY NURSING SERVICES

Individual's Name	Qualifying Treating Physician's Name
Individual's Medicaid Billing Number	Qualifying Treating Physician's Billing Number

About the ODM 07137 Form: Pursuant to 5160-12 of the Administrative Code, this form must be used to certify the medical necessity for home health services (Section I or II) and/or private duty nursing services (Section III) as ordered for the above-named individual by a qualifying treating physician. Only the qualifying treating physician may certify medical necessity. The form is also used to document a face-to-face encounter occurred with the above-named individual, as required and completed by the qualifying treating physician within ninety days prior to the start of home health care date, or within thirty days following the start of care date (OAC 5160-12-01). Under no circumstances does this certification constitute a determination of a level of care for waiver eligibility or admission to a Medicaid-covered long-term care institution. **NOTE:** An individual's plan of care may be used to document medical necessity for home health services in lieu of this form, provided all of the data elements specified below in Section I are adequately contained in a prior authorized/approved plan of care.

About Home Health Services: Home health aide, home health (intermittent) nursing, and home health skilled therapies are covered by the Ohio Department of Medicaid (ODM) when certified as medically necessary and only if provided on a part-time or intermittent basis, which means: (1) No more than a combined total of eight hours per day of home health nursing, home health aide, and skilled therapies except as specified in 5160-12 of the Administrative Code for individuals under age twenty-one; (2) No more than a combined total of fourteen hours per week of home health nursing and home health aide services except as specified in 5160-12 of the Administrative Code or as prior authorized by ODM or its designee; and (3) Visits are not more than four hours in length. Pursuant to 5160-12-01 of the Administrative Code, home health services, additional home health service hours, and/or a combination of services may be certified as medically necessary for: (I) individuals with no related inpatient hospital stay, including individuals under age twenty-one and those under twenty-one in need of increased home health services under Healthchek; and (II) individuals discharged from a covered inpatient hospital stay, including individuals under age twenty-one, and those individuals under age twenty-one in need of increased home health services under Healthchek.

About Private Duty Nursing (PDN) Services: PDN services are covered by ODM when certified as medically necessary and only when continuous nursing service(s) that require the skills of either a registered nurse (RN) or a licensed practical nurse (LPN) at the direction of a registered nurse are performed. A covered PDN visit must meet the conditions imposed in 5160-12-02 of the Administrative Code, the definition for PDN in 5160-12-04 of the Administrative Code, and be more than four hours in length but less than or equal to twelve hours in length per nurse, on the same date or during a twenty-four hour time period, unless exceptions noted in 5160-12-02(A) (1) – (A) (3) of the Administrative Code apply.

SECTION I of III

Certificate of Medical Necessity of Home Health Services for Individuals with Unrelated/Uncovered Inpatient Hospital Stay

Check all boxes that apply:

☑ By my signature below, I certify that I am the qualifying treating physician for the above-named individual and that the individual needs medically necessary home health services unrelated to an inpatient hospital stay. I certify that I ordered home health services for the treatment of individual's illness or injury unrelated to an inpatient hospital stay that are appropriate for the individual's diagnosis, prognosis, functional limitations and medical conditions.

☐ By my signature below, I certify that I am the qualifying treating physician for the above-named individual under age twenty-one and that the individual needs medically necessary, increased home health services unrelated to an inpatient hospital stay. I certify that I ordered increased home health services for the treatment of individual's illness or injury unrelated to an inpatient hospital stay that are appropriate for the individual's diagnosis, prognosis, functional limitations and medical conditions.

☑ By my signature below, I certify that I, or a collaborating advance practice nurse, or a physician assistant under my supervision conducted and documented a face-to-face encounter with the above named individual within ninety days prior to the home health services start of care date, or within thirty days following the start of care date, preceding this certification of medical necessity.

Name and Credentials of Person who Conducted the Face-to-Face Encounter	Face-to-Face Encounter Date
Certifying Physician's Signature and Credentials	Certifying Physician's Signature Date