



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 11/1/18)
- 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 4/30/20 (unless insurance dictates otherwise)
- Epinephrine 1:1000 (1 mg/ml) ampule Disp #1. Sig: Inject 0.01 mg/kg SQ 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

Physician signature: _____ **Date/Time:** _____

Physician name: _____ NPI #: _____ Practice name: _____

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

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