



# STATEMENT OF MEDICAL NECESSITY

RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS

FAX COMPLETED FORM TO RSV CONNECTION™ AT: 866-252-1749  
FOR QUESTIONS, CONTACT RSV CONNECTION™ AT: 877-RSV-9010

CuraScript, Inc. Ph: 866.297.0933 Fax: 866.297.0934  
Preferred Specialty Pharmacy

## PATIENT INFORMATION

Last Name	First Name	Middle Initial
Street Address		City
County	State	ZIP code
Date of Birth	Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Primary Guardian	Secondary Guardian	
Day Telephone (+ Area Code)	Night Telephone (+Area Code)	
Patient one of multiple births? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, is sibling(s) referral being submitted simultaneously? <input type="checkbox"/> Y <input type="checkbox"/> N	

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

## PHYSICIAN INFORMATION

Prescriber's Name	Institution / MD Practice	Office Contact
Address	City/State/ZIP	Telephone Number (+Area Code)
Prescriber's License Number	DEA Number	Fax Number (+ Area Code)
Medicaid Provider Number	NPI Number	
Supervising Physician's Name (If required for mid-level Practitioner)	License Number	

## CLINICAL INFORMATION

### PRIMARY DIAGNOSIS:

Patient's Gestational Age (GA) \_\_\_\_\_ wks \_\_\_\_\_ days Birth Weight \_\_\_\_\_ kg or \_\_\_\_\_ lbs  
Current Weight \_\_\_\_\_ kg or \_\_\_\_\_ lb Date Recorded \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> Congenital Heart Disease (745.0-747.9) Specify _____            | <input type="checkbox"/> 27-28 weeks' GA (765.24); < 12 mo. of age |
| <input type="checkbox"/> Chronic Respiratory Disease in Perinatal Period (CLD) (770.7)   | <input type="checkbox"/> 29-30 weeks' GA (765.25); < 6 mo. of age  |
| <input type="checkbox"/> Congenital anomalies of the airway (748); < 12 mo. of age       | <input type="checkbox"/> 31-32 weeks' GA (765.26); < 6 mo. of age  |
| <input type="checkbox"/> Severe Neuromuscular Disease (358); < 12 mo. of age             | <input type="checkbox"/> 33-34 weeks' GA (765.27)                  |
| <input type="checkbox"/> Other respiratory conditions of fetus and newborn (770.0-770.9) | <input type="checkbox"/> 35-36 weeks' GA (765.28)                  |
| <input type="checkbox"/> < 24 weeks' GA (765.21 - 765.22); < 12 mo. of age               | <input type="checkbox"/> 37 or more weeks' GA (765.29)             |
| <input type="checkbox"/> 25-26 weeks' GA (765.23); < 12 mo. of age                       |  |
| <input type="checkbox"/> Other _____   | Secondary diagnosis (if applicable) _____                          |

### MEDICAL CRITERIA:

- Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age?   
Is patient receiving medical treatment of (check all that apply & provide last date received):  
 Oxygen: \_\_\_\_\_  Bronchodilator: \_\_\_\_\_  Diuretics: \_\_\_\_\_  Corticosteroids: \_\_\_\_\_
- Diagnosis of hemodynamically significant congenital heart disease (CHD) and less than 24 months of age?   
Patient has the following condition:  
 Medications for CHD: \_\_\_\_\_ Last date received: \_\_\_\_\_  
 Diagnosis of moderate-severe pulmonary hypertension  
 Cyanotic CHD
- If the infant is 32-35 weeks GA, then check all risk factors that apply:  
 Pre-School or School-Aged Sibling(s)  Young chronologic age ≤ 12 weeks  
 Daycare attendance outside of the home  
**Additional Risk Factors**  
 Crowded living conditions  Exposure to environmental tobacco smoke  
 Exposure to environmental air pollutants  Birth weight <2500g  
 Severe neuromuscular disease  Multiple births  
 Congenital abnormality of airway  Family history of asthma  
 None  Residency in rural setting  
Other medical history: \_\_\_\_\_

### NICU/HOSPITAL HISTORY:

- Did the patient spend time in the NICU or Special Care Nursery?  Yes  No  
If yes, please attach the 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

Deliver product to:  MD Office  Patient's Home  Clinic: Clinic Location: \_\_\_\_\_  
Home Health Nurse Requested?:  Yes  No Agency Name: \_\_\_\_\_

**Rx**  Synagis® (palivizumab) 50- and/or 100-mg vials Refills \_\_\_\_\_  
Sig: Inject 15 mg/kg IM one time per month (every 28-30 days) Dispense Quantity: QS  
 Synagis® Supply Kit (swabs, band aids, 3 ml 25g 5/8 syr, 25 g 1" needle) Qty 2 Refills \_\_\_\_\_  
 Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg SC as directed  
 Known Allergies: \_\_\_\_\_

Dr. \_\_\_\_\_ Dr. \_\_\_\_\_  
Substitution Permitted \_\_\_\_\_ Dispense as Written \_\_\_\_\_  
Date: \_\_/\_\_/\_\_\_\_



This form is for data collection and includes a new Synagis Rx to CuraScript, but should not be interpreted as a clinical guideline or prior authorization. Currently there is no generic substitution for Synagis.