SYNAGIS® PALIVIZUMAB

STATEMENT OF MEDICAL NECESSITY

RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name | First Name | Middle Initial

Street Address | City

County | State | ZIP Code

❑ M ❑ F

Date of Birth | Social Security Number | Sex

Parent/Guardian

Day Telephone (+Area Code) | Night Telephone (+Area Code)

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)

Group Number | Group Number

Policy Number | Policy Number

Insurance Telephone Number (+Area Code) | Insurance Telephone Number (+Area Code)

Employer

2 PHYSICIAN INFORMATION

Prescriber's 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 | UPIN Number

Supervising Physician's Name (If Required for Mid-Level Practitioner) | License Number

3

McLAREN HEALTH PLAN
A McLAREN HEALTH SERVICE
HEALTHADVANTAGE

Fax to 4D Pharmacy Management for authorization: 248.540.9811

Drug provided by:
McKesson Specialty Pharmacy Services
Fax: 1.888.591.8482, Phone: 1.888.456.7274

McKESSON
Empowering Healthcare

4 CLINICAL 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)
❑ Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (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)
❑ Other_____

❑ 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 week's GA (765.29)
❑ Congenital Anomalies of Respiratory System (748)

Secondary diagnosis (if applicable)_____

MEDICAL CRITERIA:

1. Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age? ❑ Yes ❑ No
   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 and less than 24 months of age? ❑ Yes ❑ No
   Patient has the following condition: ❑ Diagnosis of moderate–severe pulmonary hypertension
   ❑ Medications for CHD:_____ Last date received:_____
3. Prematurity:
   ❑ Gestational age of ≤28 weeks and <12 months of age at the start of RSV season
   ❑ Gestational age of 29–32 weeks and <6 months of age at the start of RSV season
   ❑ Gestational age of 32–35 weeks and <6 months at the start of RSV season, and clinically has the following risk factors (Check all that apply):
   - ❑ School-age siblings
   - ❑ Exposure to environmental air pollutants
   - ❑ Day care
   - ❑ Severe neuromuscular disease
   - ❑ Congenital abnormality of airway
   - ❑ Birth weight less than 2500 g
   - ❑ Crowded living conditions
   - ❑ Multiple birth
   - ❑ Family history of asthma
   - ❑ *No other clinical risk factors*

Other medical history:_____

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

Deliver product to: ❑ Office ❑ Patient's Home ❑ Clinic Clinic Location:_____

Agency nurse to visit home for injection? ❑ Yes ❑ No Agency Name:_____

Rx

❑ Synagis® (palivizumab) 50- and/or 100-mg vials and Sterile Water for injection 10 mL (for lyophilized formulation only)*

Sig: Reconstitute as directed and inject 15 mg/kg IM one time per month (for lyophilized formulation only) OR

Sig: Inject 15 mg/kg IM one time per month (for liquid formulation only)

Dispense Quantity: QS Refill_____ months

❑ Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed ❑ Known Allergies:_____

❑ Other_____

Sig:_____

Prescriber's Signature_____

*Synagis® liquid formulation will be automatically substituted upon manufacturers' market release.