



STATEMENT OF MEDICAL NECESSITY
RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS
Complete form in its entirety and fax to number listed below

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PATIENT INFORMATION

Last Name	First Name	Middle Initial
Street Address	City	
County	State	ZIP Code <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth	Sex	
Parent/Guardian		

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	Cardholder Name
Group Number	Group Number
Policy Number	Policy Number
Insurance Telephone Number (+Area Code)	Insurance Telephone Number (+Area Code)
Employer	

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

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For Predetermination review, fax completed form to:



Allan J. Chernov, M.D., Medical Director
Health Care Quality & Policy
972-766-5559

BlueCross BlueShield
of Texas

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CLINICAL INFORMATION

PRIMARY DIAGNOSIS:

Patient's Gestational Age (GA) (Weeks/Days) _____ Birth Weight _____ kg (lb)
 Current Weight _____ kg (lb) Date Recorded _____

Congenital Heart Disease (745.0-747.9) 29-30 weeks' GA (765.25)
 Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7) 31-32 weeks' GA (765.26)
 ≤24 weeks' GA (765.21-765.22) 33-34 weeks' GA (765.27)
 25-26 weeks' GA (765.23) 35-36 weeks' GA (765.28)
 27-28 weeks' GA (765.24) 37 or more week's GA (765.29)
 Other Respiratory Conditions of Fetus and Newborn (770.0-770.9) Congenital Anomalies of Respiratory System (748)
 Other _____ Secondary diagnosis (if applicable) _____

MEDICAL CRITERIA:

- Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age? Yes No
 Is patient receiving medical treatment for CLD/BPD? (check all that apply and provide last date received): Oxygen Date: _____
 Corticosteroid Date: _____ Bronchodilator Date: _____ Diuretic Date: _____
- Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age? Yes No
 Diagnosis of moderate-severe pulmonary hypertension? Yes No
 Medications for CHD: _____ Date last received: _____
- Prematurity: Gestational age of ≤28 weeks, 6 days and <12 months of age at the start of RSV season
 Gestational age of 29 weeks, 0 days to 31 weeks, 6 days and <6 months of age at the start of RSV season
 Gestational age of 32 weeks, 0 days to 34 weeks, 6 days and <3 months at the start of RSV season, AND has the following risk factors (Check all that apply):
 Sibling(s) younger than age 5 Child care attendance
 None
 Gestational age of ≤34 weeks, 6 days and <12 months of age at the start of RSV season, with diagnosis of: Congenital abnormality of the airway Severe neuromuscular disease
- Diagnosis of severe immunodeficiency and less than 24 months of age? Yes No

Other significant medical history: _____

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.