



Fax Completed Form to:
LDI Integrated Pharmacy
Services
1-314-652-4126

SYNAGIS® (PALIVIZUMAB)
REFERRAL & STATEMENT OF MEDICAL NECESSITY
For Question Call (866) 516-4121

SECTION 1: Patient Information

Form with fields: Last Name, First Name, Middle Initial, Date of Birth, Identification Number, Street Address, City, State, Zip Code, Gender, Daytime Phone, Evening Phone.

INSURANCE INFORMATION \*Include Copies of Insurance Card

Form with fields: Primary Insurance, Cardholder Name & Social Security Number, Group/Policy Number, Insurance Telephone Number, Secondary Insurance, Primary Employer, Secondary Employer.

SECTION 2: Physician Information

Form with fields: Prescriber's Name, Hospital/Clinic, Office Contact, Address, City/State/Zip, Telephone Number, Prescriber's License Number, DEA Number, Fax Number, Medicaid Provider Number, UPIN Number, Supervising Physician's Name.

SECTION 3: Prescription

Form with prescription options: Synagis® (palivizumab) Liquid Solution, Epinephrine 1:1000 Amp, Known Allergies, and Prescribing Physician's Signature/Date.



# STATEMENT OF MEDICAL NECESSITY

**\*Completion of Section 4 Required on all Referrals  
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## SECTION 4: Clinical Information

### PRIMARY DIAGNOSIS

Patient's Gestational Age: \_\_\_\_\_ Birth Weight: \_\_\_\_\_g/kg/lb

Current Weight: \_\_\_\_\_g/kg/lb Date Recorded: \_\_\_\_\_

- Congenital Heart Disease (747.0-745.4)
- Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)
- ≤ 24 weeks of gestation (765.21-765.22)
- 25-26 weeks of gestation (765.23)
- 27-28 weeks of gestation (765.24)
- 29-30 weeks of gestation (765.25)
- 31-32 weeks of gestation (765.26)
- 33-34 weeks of gestation (765.27)
- 35-36 weeks of gestation (765.28)
- 37 weeks of gestation (765.29)
- Congenital Anomalies of Respiratory System (748.3-748.4)
- Other Respiratory Conditions of Fetus and Newborn (770.0-770.9)
- Other: \_\_\_\_\_ Secondary Diagnosis: \_\_\_\_\_

### MEDICAL CRITERIA:

1. Diagnosis of Chronic Pulmonary Disease (CLD/BPD) & < 24 months of age?
  - Yes  No
  - Is patient receiving medical treatment of (√ 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 <24 months of age?  Yes  No  
Patient has the following conditions:
  - Diagnosis of moderate-severe pulmonary hypertension
  - Cyanotic heart disease
  - Medications for CHD: \_\_\_\_\_ Last Date Received: \_\_\_\_\_
3. Prematurity:
  - Gestational age of ≤ 28 wks & < 12 months of age at start of RSV season
  - Gestational age of 29-32 wks & < 6 months of age at start of RSV season
  - Gestational age of 32-35 wks & < 6 months of age at start of RSV season
  - ≥ 2 risk factors
  - NO risk factors

### Check all of the risk factors that apply:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Day Care                                 | <input type="checkbox"/> School age siblings      | <input type="checkbox"/> Severe neuromuscular disease          |
| <input type="checkbox"/> Exposure to environmental air pollutants | <input type="checkbox"/> Family history of asthma | <input type="checkbox"/> Multiple birth                        |
| <input type="checkbox"/> Congenital anomalies of airway           | <input type="checkbox"/> None                     | <input type="checkbox"/> Limited availability of hospital care |
|   |   | <input type="checkbox"/> Low birth weight (<2500 grams)        |
|   |   | <input type="checkbox"/> Other _____                           |

**NICU History:**  Yes  No Please attach the NICU Discharge Summary

Was there a NICU/Hospital dose administered?  Yes  No Date(s): \_\_\_\_\_

**Expected date of first/next injection:** \_\_\_\_\_

**Previous Injections?**  No  Yes Date(s): \_\_\_\_\_

**Deliver product to:**  Doctor's office  Home Care Agency  Other: \_\_\_\_\_

Agency nurse to visit home for injection?  Yes  No