



**2008-2009 SYNAGIS MEDICAL NECESSITY FORM  
RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS**

**ST. JOHN'S  
HEALTH SYSTEM**

**Complete form in its entirety and fax to  
St. John's Home Care @417-820-5552**

**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	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

**OFFICE USE ONLY**

Authorization:  Approved  Denied Authorization Number: \_\_\_\_\_  
 Previous Synagis Prophylaxis Dates: 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_

**3**

**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)  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 (Check all that apply):**

- Diagnosis of chronic pulmonary disease (CLD/BPD) and ≤ 24 months of age? (Send Records)
- Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age? (Send Records)
- 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* has two of the following required risk factors  
 (Check all that apply):  
 School-age siblings  Exposure to non-modifiable environmental air pollutants (i.e. wood burning)  
 Day care  Severe neuromuscular disease  
 Congenital abnormality of airway
- Other Diagnosis: \_\_\_\_\_

**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

**RX:**

**Synagis® (palivizumab) 50- and/or 100-mg vials and Sterile Water for injection 10 mL (for lyophilized formulation only)\***  
 Sig: Inject 15 mg/kg IM one time per month (for liquid formulation only)  
 Dispense Quantity: \_\_\_\_\_ Refill \_\_\_\_\_ months  
 Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed  Known Allergies: \_\_\_\_\_  
 Other \_\_\_\_\_

Sig: \_\_\_\_\_

Check acceptable locations of service:  Any  Office  Home Health  Outpatient

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_





2008-2009 SYNAGIS MEDICAL NECESSITY FORM  
RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS

Complete form in its entirety and fax to  
St. John's Health Plans @ 417-820-6318 or 800-863-8040

PATIENT INFORMATION

Form fields for Patient Information: Last Name, First Name, Middle Initial, Date of Birth, Social Security Number, Sex, Parent/Guardian, County, Address, City/State, ZIP Code, Phone: Home, Work, Cell, Additional Contact Person, Phone.

INSURANCE INFORMATION

Form fields for Insurance Information: Primary Insurance, Policy #, Cardholder Name & Social Security Number (If Not Patient), Group #, Employer, Insurance Telephone Number (+ area code), Secondary Insurance, Policy Number, Cardholder Name & Social Security Number (If Not Patient), Group #, Employer, Insurance Telephone Number (+ area code).

OFFICE USE ONLY

Authorization: [ ] Approved [ ] Denied Authorization Number: \_\_\_\_\_  
[ ] Previous Synagis Prophylaxis Dates: 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_  
Check acceptable locations of service: [ ] Any [ ] Office [ ] Home Health [ ] Outpatient

2 PEDIATRICIAN/PHYSICIAN INFORMATION

Form fields for Pediatrician/Physician Information: Attending Physician 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, NPI, License #.

3

Place Patient ID Label Here  
(if applicable)

NEWBORN INFORMATION

PRIMARY DIAGNOSIS:

Form fields for Newborn Information: Patient's Gestational Age (GA), Birth Weight, Current Weight, Date Recorded, Congenital Heart Disease (745.0-747.9), Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7), Other Respiratory Conditions of Fetus and Newborn (770.0-770.9), Congenital Anomalies of Respiratory System (748), Other Secondary diagnosis (if applicable).

NICU HISTORY:

Form fields for NICU History: Did the patient spend time in the NICU? [ ] Yes [ ] No, Was RSV prophylaxis recommended by the NICU/HOSPITAL physicians for this patient? [ ] Yes [ ] No, Was there a NICU/HOSPITAL dose administered? [ ] Yes [ ] No, EXPECTED DATE OF FIRST/NEXT INJECTION: \_\_\_\_\_ Injection already given? [ ] Yes [ ] No, NICU/Referral Physician (printed name): \_\_\_\_\_, NICU/Referral Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICAL CRITERIA (Check all that apply):

- 1. [ ] Diagnosis of chronic pulmonary disease (CLD/BPD) and ≤ 24 months of age? (Send Records)
- 2. [ ] Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age? (Send Records)
- 3. [ ] 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 has two of the following required risk factors (Check all that apply):  
[ ] School-age siblings [ ] Exposure to non-modifiable environmental air pollutants (i.e. wood burning)  
[ ] Day care [ ] Severe neuromuscular disease  
[ ] Congenital abnormality of airway
- 4. [ ] Other Diagnosis: \_\_\_\_\_

RX:

Synagis® (palivizumab) 50- and/or 100-mg vials  
Sig: Inject 15 mg/kg IM one time per month (for liquid formulation only)  
Dispense Quantity: \_\_\_\_\_ Refill \_\_\_\_\_ months  
[ ] Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed [ ] Known Allergies: \_\_\_\_\_  
[ ] Other \_\_\_\_\_  
Sig: \_\_\_\_\_

Attending Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

