CoxHealth at Home

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Springfield, MO 65807
Ph: 855-419-4663

Synagis® (Palivizumab)
Statement of Medical Necessity Form
FAX: 417-269-0692

First name | Middle initial | Last name

Street address | City

County | State | ZIP code

Date of birth (month/day/year) | Sex ☐ M ☐ F | Social security number

Primary guardian | Secondary guardian

Day telephone (+ area code) | Night telephone (+ area code)

Patient one of multiple births? ☐ Yes ☐ No
If yes, is sibling(s) referral being submitted simultaneously? ☐ Yes ☐ No

Sibling name(s)

☐ No insurance ☐ Unknown
Include copies of the patient's insurance cards and drug benefit cards (front and back).

Primary insurance | Secondary insurance

Cardholder name (if not patient) DOB | Cardholder name (if not patient) DOB

Policy number | Policy number

Group number | Group number

Insurance telephone number (+ area code) | Insurance telephone number (+ area code)

Employer

Prescriber Information

Provider Name

Site Name

Site Address (City, State, & Zip

Telephone # /Fax #

Office Contact

NPI #

License # / Tax ID #

Medicaid # / DEA #

Clinical Information

PRIMARY DIAGNOSIS:

Patient's gestational age (GA) **Birth weight kg/lb** **Current weight kg/lb** **Date current weight recorded**

☐ Congenital heart disease (745.0–747.9)
☐ Chronic respiratory disease arising in the perinatal period (770.7)
☐ Other respiratory conditions of fetus and newborn (770.0–770.9)
☐ Congenital anomalies of respiratory system (748)
☐ Other

☐ ≤24 completed weeks of gestation (765.21 –765.22)
☐ 25–26 completed weeks of gestation (765.23)
☐ 27–28 completed weeks of gestation (765.24)
☐ 29–30 completed weeks of gestation (765.25)
☐ Secondary diagnosis (if applicable)

☐ 31–32 completed weeks of gestation (765.26)
☐ 33–34 completed weeks of gestation (765.27)
☐ 35–36 completed weeks of gestation (765.28)
☐ ≥37 completed weeks of gestation (765.29)

MEDICAL CRITERIA: ☐ Medical records included

1. ☐ **Diagnosis of chronic lung disease of prematurity/bronchopulmonary dysplasia (CLDP/BPD) and ≤24 months of age**
   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 (CHD) and ≤24 months of age
   Patient has the following condition:
   ☐ Medications for CHD: ☐ Diagnosis of moderate to severe pulmonary hypertension
   ☐ Last date received: ☐ Cyanotic CHD

3. **If the infant is 32 35 weeks GA, then check all risk factors that apply:**
   ☐ Young chronological age (≤12 weeks) ☐ Pre-school or school - aged sibling(s) <5 years of age ☐ Daycare attendance

   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 airways ☐ Family history of asthma or wheezing ☐ Residency in rural setting

   Other medical history:

4. Siblings (Name, Age, Birthdate)

HOSPITAL HISTORY:

Did the patient spend time in the NICU/PICU/special care nursery? ☐ Yes ☐ No If yes, please attach the discharge summary.
Was Synagis® (palivizumab) administered in the NICU/hospital? ☐ Yes ☐ No Date(s):

*Req. Expected date of first/next dose: Dose already given? ☐ Yes Date(s): ☐ No Please complete month and day to indicate if next dose is to be given: month/day/year

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 mg and/or 100 mg vials. Inject 15 mg/kg IM one time per month. QS to achieve 15 mg/kg dose Refills: *Req.
☐ Known allergies:

*Req. Prescriber's signature (required) **Date**

*Req. = Required

This form should not be construed as coding advice. Each practitioner is solely responsible for ensuring the accuracy of the information submitted. 9/3/19