Vital Care of Meridian

Synagis™ Statement of Medical Necessity

PH: 601-482-4003 / 1-877-229-1724

FAX: 1-877-229-1725

Clinic #:

VITAL CARE Home Infusion Services

Patient Information

Patient Name:		**SSN:**	**DOB:**
Gender:	**Guardians:**	**Home Phone**	**Cell or Other**
Address:		**City/State/Zip:**	

Insurance Information: Please send copy of Insurance card(s), if available

Primary Insurance:	**Secondary Insurance:**
Policy Number:	**Policy Number:**
Group Number:	**Group Number:**

Primary Diagnosis:

Actual gestational age: _____wks _____ days Birth Wt: _____lb_____oz Current Wt_____lb_____oz Date: _____

- ☐ Congenital Heart Disease (Q20.0 - Q28.9) _____
- ☐ Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (P27.0; P27.1; P27.8)
- ☐ *less than or equal to* 24 weeks GA (P07.2; P07.22; P07.23)
- ☐ 25-26 weeks GA (P07.24 ; P07.25)
- ☐ 27-28 weeks GA (P07.26 ; P07.31)
- ☐ Other Respiratory Conditions of Fetus and Newborn (P27.0; P27.1; P27.8)
- ☐ Other _____
- ☐ 29-30 weeks GA (P07.32; P07.33)
- ☐ 31-32 weeks GA (P07.34; P07.35)
- ☐ 33-34 weeks GA (P07.36; P07.37)
- ☐ 35-36 weeks GA (P07.38 ; P07.39)
- ☐ 37 or more weeks GA _____
- ☐ Congenital Anomalies of Respiratory System (Q30.0)
- ☐ Secondary Diagnosis (if applicable)_____

Clinical Criteria:

Medical records included ☐ Yes ☐ No

NICU History ☐Yes ☐ No NICU Name _____ **(Please Attach the NICU Discharge Summary)**

Dose Given ☐Yes ☐ No NICU Injection date_____

1. ☐ **BPD/CLDP: Diagnosis of bronchopulmonary dysplasia/chronic lung disease of prematurity and ≤24 mon**ths of age
   (Specific Diagnosis Code: _____)
   Is patient receiving medical treatment (check all that apply and provide last date received)?:
   ☐ Oxygen date: _____ ☐ Corticosteroids date: _____ ☐ Bronchodilators date: _____ ☐ Diuretics date: _____

2. ☐ **CHD: Diagnosis of hemodynamically significant congenital heart disease and ≤24 months of age**
   (Specific Diagnosis Code: _____)
   Patient has any of the following (check all that apply):
   ☐ Medications for CHD:_____ ☐ Moderate to severe pulmonary hypertension
   Date CHD medications were last received: _____ ☐ Cyanotic CHD

3. **Indicate applicable risk factors** : ☐ Pre-school or school-aged sibling(s) ☐ (<5 years of age) Child Care Attendance

Rx: Info

Rx: Synagis™, (Palivizumab)

Sig: Inject 15mg/kg every 4 weeks during RSV season. Refill monthly thru RSV season.

Physician Signature:_____ Date:_____

Physician Information

Physician's Name:	**Office Contact:**
Hospital / Clinic:	**Phone:**
Address:	**Fax:**
City / State / Zip	**DEA#**
NPI #	**Medicaid #**

Please FAX to: 1-877-229-1725