Vital Care Rx

Synagis™ Statement of Medical Necessity
PH: 601-482-4003 / 1-877-229-1724
FAX: 1-877-229-1725

vitalcare SPECIALTY

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 #

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Please FAX to: 1-877-229-1725