



Statement of Medical Necessity

Respiratory Syncytial Virus (RSV) Prophylaxis



1 COMPLETE FORM IN ITS ENTIRETY AND FAX TO:
RSV Connections™
Fax: 1-866-252-1749

Questions? Visit us on the web at www.AetnaSpecialtyPharmacy.com, or call Aetna Specialty Pharmacy® toll-free at 1-866-503-0857.

2 **PATIENT INFORMATION**

Last Name		First Name	Middle Initial
Street Address		City	
County	State	ZIP Code	
Date of Birth (MM/DD/YYYY)	Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Parent/Guardian			
Day Telephone (+Area Code)		Evening 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
Employer	

3 **PHYSICIAN INFORMATION**

Prescriber's Name	Hospital/Clinic	Office Contact	
Address	City/State/ZIP	Telephone Number (+Area Code)	
State License Number	NPI Number	DEA Number	Fax Number (+Area Code)
Medicaid Provider Number	UPIN Number		
Supervising Physician's Name (If Required for Mid-Level Practitioner)	License Number		

4 **CLINICAL INFORMATION**

Will Aetna Specialty Pharmacy be providing Synagis for other siblings? Yes No NAMES: _____

Current Weight _____ kg (lb) _____ (oz) Date Recorded: ____/____/____ Gestational Age days _____ weeks _____

Was there a NICU dose administered? Yes Date Received: ____/____/____ No

- Infants born at ≤ 28 + 6 weeks gestation who are less than 12 months of age at the start of RSV season:
 765.21-765.24 List diagnosis code _____
- Infants born at 29 + 0 to 31 + 6 weeks gestation who are less than 6 months of age at the start of RSV season:
 765.25-765.26 List diagnosis code _____
- Infants born between 32 + 0 to 34 + 6 weeks gestation who are younger than 3 months of age with one of the two qualifying risk factors present. Note: **AAP guidelines indicate coverage for the first 3 months of life only.**
 765.26-765.27 List diagnosis code _____
 Risk factor(s): Sibling less than 5 years at RSV season start
 Child care attendance outside the home

- Infants born ≤ 34 + 6 weeks gestation and are less than 12 months of age who have either congenital abnormalities of the airway or a neuromuscular condition:
 358.0-358.9 Myoneural disorders (severe neuromuscular disease) List diagnosis code _____
 748.5 Agenesis, hypoplasia, and dysplasia of lung (congenital anomaly of airway)
 748.6-748.69 Other anomalies of lung (congenital anomaly of airway) List diagnosis code _____

- Infants/children who are < 24 months of age at start of RSV season with the diagnosis of chronic lung disease requiring medical therapy (supplemental oxygen, bronchodilator, and diuretic or corticosteroid therapy) within 6 months before anticipated RSV season:
 416.0-416.9 Chronic pulmonary heart disease/chronic lung disease List diagnosis code _____
 491.0-491.9 Chronic bronchitis List diagnosis code _____
 493.20-493.22 Chronic obstructive asthma List diagnosis code _____
 496 Chronic airway obstruction
 770.7 Bronchopulmonary Dysplasia List diagnosis code _____
 List MEDS: _____ Last received MEDS: ____/____/____

- Infants/children with hemodynamically significant cyanotic and acyanotic congenital heart disease, receiving medication to control congestive heart failure, or infants with severe immunodeficiencies, who are < 24 months of age at the onset of RSV season:
 745.0-747.5 Bulbous cord anomalies and anomalies of cardiac septal closure, other congenital anomalies of heart, and other anomalies of circulatory system List diagnosis code _____ If VSD, list SIZE _____
 279.0-279.9 Disease involving the immune mechanism List diagnosis code _____
 428.0 Congestive heart failure, unspecified List MEDS: _____
 Last received MEDS: ____/____/____

Other Medical History: _____

EXPECTED DATE OF FIRST/NEXT INJECTION: ____/____/____ Injection already given? Yes Date: ____/____/____ No

Who will be dispensing Synagis? Aetna Specialty Pharmacy Other Pharmacy: _____ Doctor's Office

Deliver product to: Office Patient's Home Clinic (location): _____

Home Health Nurse Requested? Yes Agency Name: _____ No

Rx

- Synagis® (palivizumab) 50- and/or 100-mg vials
 Sig: Inject 15 mg/kg IM one time per month Refill ____ months
- Dispense Quantity: QS
- Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed
- Known Allergies: _____

Prescriber's Signature _____ Date ____/____/____