STATEMENT OF MEDICAL NECESSITY (SMN)

SYNAGIS® PALIVIZUMAB

Note: This form is intended for prescriber use only. If faxed, the fax must come from the MDO office or hospital. (may not be faxed by patient)

***** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *****

Specialty Pharmacy Provider: **AllianceRx Walgreens Pharmacy** Phone: **888-282-5166** Fax: **855-569-2511**

2 PATIENT INFORMATION

Name (First, Last):	Primary Guardian:
DOB: SSN:	Secondary Guardian:
Gender: ☐Male ☐Female	Home Phone # / Mobile Phone #:
Primary Language: ☐English ☐Spanish ☐Other:	Patient one of multiple births? ☐Yes ☐No If yes, how many:
Address Street:	If yes, is sibling(s) referral being submitted simultaneously? ☐Yes ☐No
City: State: Zip:	

3 INSURANCE INFORMATION

☐No Insurance ☐Include copies of front and back of Medical and Pharmacy cards *(If copies are included, you do not need to rewrite card information)*

	PRIMARY INSURANCE	SECONDARY INSURANCE	PHARMACY BENEFIT
Insurance Name:			
Cardholder Name (if not patient) /DOB:			
Group #:			
Policy # / Patient ID #:			
Insurance Phone #:			
BIN # / PCN # (pharmacy only):			

Independent Practice Association (IPA) / Accountable Care Organization (ACO) (if applicable):
Did the patient receive a dose in hospital? ☐Yes ☐No

4 PRESCRIBER INFORMATION

	TREATING	REFERRING (OPTIONAL)
Prescriber Name:		
Practice Site Name:		
Office Contact:		
Telephone # / Fax #:	/	/
Address:		
NPI #:		
License# / Tax ID #:	/	/
Medicaid Provider # / DEA #:	/	/

5 CLINICAL INFORMATION

Patient's gestational age (GA) at birth: _____ Current weight: _____ kg_____ lbs-oz Date current weight recorded: _____

Diagnosis Code(s):

CLINICAL INFORMATION: Birth weight: _____ kg_____ lbs-oz ☐Medical records included

1. ☐**BPD/CLDP: Diagnosis of bronchopulmonary dysplasia/chronic lung disease of prematurity and ≤ 24 months 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:**
   ☐Congenital abnormality of airways ☐Severe neuromuscular disease ☐Pre-school or school-aged sibling(s) (<5 years of age)
   ☐Family history of asthma or wheezing ☐Residency in rural setting ☐Daycare – care at any home or facility with any number of infant or young toddlers
   ☐Multiple births ☐Exposure to environmental tobacco smoke or air pollutants

6 PRESCRIPTION INFORMATION

Please see Important Safety Information on the following page.

Was Synagis® (palivizumab) previously administered (NICU/hospital/other location)? ☐No ☐Yes Date(s) _____

Expected date of first/next dose: _____

Deliver product to: ☐Office ☐Patient's home ☐Clinic Clinic Name and Location: _____

Agency nurse to visit home for injection monthly throughout Synagis Season ☐No ☐Yes Agency Name (if known): _____

Home Administration: EPI _____ Supplies _____

Rx Synagis 50 mg and/or 100 mg vials. Inject 15 mg/kg IM one time per month. QS to achieve 15 mg/kg dose. ***REFILLS:*** **(Please enter "0" if no refills remain)** _____ **** Required***

☐Epinephrine 1: 1000 amp. Sig: Inject 0.01 mg/kg IM/SC as directed ☐Known allergies: _____

☐Ancillary supplies and kits as needed for administration: _____

Attestation of Authorization

By signing this form, I certify that I have the necessary authorization to release the information included on this form and other protected health information (as defined by HIPAA), and receive information on the status and related matters, to Sobi SYNAGIS CONNECT, including employees, contractors, or affiliates of Sobi, and healthcare plans for programs, dispensing pharmacy or other entities, for the purposes of treatment and payment support. If not already received, I give SYNAGIS CONNECT permission to contact this patient to obtain Patient Authorization.

Required * **Original signature of prescriber:** _____ **Date:** _____

(Brand medically necessary)

Original signature of prescriber: _____ **Date:** _____ **** Required***

(Substitution _____ permissible)