

# Vital Information

Synagis™ Statement of Medical Necessity

PH: 318-673-8360

FAX: 318-673-8940

vitalcare®

of SHREVEPORT

## 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: \_\_\_\_\_

<input type="checkbox"/> Congenital Heart Disease (Q20.0 - Q28.9) _____	<input type="checkbox"/> 29-30 weeks GA (P07.32; P07.33)
<input type="checkbox"/> Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (P27.0; P27.1; P27.8)	<input type="checkbox"/> 31-32 weeks GA (P07.34; P07.35)
<input type="checkbox"/> less than or equal to 24 weeks GA (P07.2; P07.22; P07.23)	<input type="checkbox"/> 33-34 weeks GA (P07.36; P07.37)
<input type="checkbox"/> 25-26 weeks GA (P07.24 ; P07.25)	<input type="checkbox"/> 35-36 weeks GA (P07.38 ; P07.39)
<input type="checkbox"/> 27-28 weeks GA (P07.26 ; P07.31)	<input type="checkbox"/> 37 or more weeks GA _____
<input type="checkbox"/> Other Respiratory Conditions of Fetus and Newborn (P27.0; P27.1; P27.8)	<input type="checkbox"/> Congenital Anomalies of Respiratory System (Q30.0)
<input type="checkbox"/> Other _____	<input type="checkbox"/> 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 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 :  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: 318-673-8940