



Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name		Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #		
Allergies: <input type="checkbox"/> NKA or _____				
Street Address			City	
State	County	Zip Code		
Parent/Guardian		Day Telephone	Night Telephone	
Emergency Contact		Relationship	Telephone	

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	
Supervising Physician's Name (If Required for Mid-Level Practitioner)		NPI Number	

WILCOX MEDICAL

Wilcox Home Infusion
250 Stratton Road
Rutland, Vermont 05701
A subsidiary of **bio scrip**
Form Last Updated 10/2015

Fax Completed Form to:

Fax Number: 855-775-7824 ☎

Phone Number: 800-639-1210 ☎

3 Department of Vermont Health Access PRIOR AUTHORIZATION REQUEST SYNAGIS® (PALIVIZUMAB)

Gestational Age: weeks: days:	Current Weight: (kg)	Dose: 15mg / kg (weight verified monthly)
Diagnosis:		
<input type="checkbox"/> Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under 12 months of age at the start of the RSV season (maximum 5 doses)		
<input type="checkbox"/> Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 days) of gestation and under 1 year of age at the start of the RSV season who develop chronic lung disease of prematurity defined as a requirement for >21% oxygen for at least the first 28 days after birth (maximum 5 doses)		
<input type="checkbox"/> Children under 24 months of age with chronic lung disease of prematurity defined as born at 31 weeks, 6 days or less who required >21% oxygen for at least the first 28 days after birth and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season (maximum 5 doses). <input type="checkbox"/> Treatment: <input type="checkbox"/> Dates of Use:		
<input type="checkbox"/> Children under 12 months of age with hemodynamically significant congenital heart disease (CHD) (dosing continues in the RSV season through the end of the month the infant reaches 12 months old -maximum 5 doses) <input type="checkbox"/> Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedure <input type="checkbox"/> Moderate to severe pulmonary hypertension <input type="checkbox"/> Cyanotic heart disease and recommended for Synagis therapy by Pediatric Cardiologist		
<input type="checkbox"/> Infants under 12 months of age with either: (dosing continues in the RSV season through the end of the month the infant reaches 12 months old – maximum 5 doses) <input type="checkbox"/> Congenital abnormalities of the airways that impairs the ability to clear secretions from the upper airway because of ineffective cough <input type="checkbox"/> Neuromuscular condition that impairs the ability to clear secretions from the upper airway because of ineffective cough		
<input type="checkbox"/> Other:		

NICU HISTORY

Did the patient spend time in the NICU?
 Yes No (If yes, please attach the NICU summary)

Was RSV prophylaxis recommended by the NICU/Hospital physician for this patient?
 Yes No

Was a NICU/Hospital /Clinic dose administered?
 Yes, Date(s): No

4 PRESCRIPTION

Synagis (palivizumab) 50 and/or 100 mg vials and supplies for administration.
 Sig: Inject 15 mg/kg IM once every 4 weeks; expected date of first home injection: _____
 Dispense Quantity: Quantity sufficient for prophylaxis thru 04/2016
 Deliver product to: MD office Patient's home Clinic
 Home health nurse to administer injection Home Health Agency: _____
 If delivery is to clinic, please give location: _____
 Pediatric Anaphylaxis: Administer 0.01 ml/kg (max 0.3ml) of 1:1000 epinephrine solution subcutaneously or intramuscularly, and contact EMS or physician, as appropriate.
 Other: _____
 Sig: _____
 Physician will monitor patient's response to therapy. Any complications in therapy will be reported to the physician either by the patient's caregiver, or the skilled nursing service (If other than physician's office or Wilcox Home Infusion)

Prescriber's Signature: _____ **Date:** _____

Supervising Physician's Signature: _____

This order is valid for the entire upcoming season if signed prior to the December dose, or for the remainder of the present season if signed after December.