



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 09/2010

**Fax Completed Form to:**

**Fax Number: 802-775-7824**

**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 6 months of age at the start of the RSV season (maximum 5 doses)		
<input type="checkbox"/> Infants born at 32 - 35 weeks (i.e., between 32 weeks, 0 days and 34 weeks, 6 days) of gestation who have at least one of the following risk factors and who have not reached 3 months of age: (dosing continues in the RSV season through the end of the month the infant reaches 3 months old – maximum 3 doses) <input type="checkbox"/> Infant attends child care <input type="checkbox"/> One or more siblings (or other child permanently in house) < 5 years of age		
<input type="checkbox"/> Children under 24 months of age with chronic lung disease of prematurity (bronchopulmonary dysplasia) who have received medical therapy (supplemental oxygen, bronchodilator, diuretic or chronic corticosteroid therapy) within 6 months prior to the start of the RSV season (maximum 5 doses) <input type="checkbox"/> Treatment: _____ <input type="checkbox"/> Dates of Use: _____		
<input type="checkbox"/> Children under 24 months of age with hemodynamically significant cyanotic or acyanotic heart disease(CHD) <input type="checkbox"/> Receiving medication to control congestive heart failure <input type="checkbox"/> Moderate to severe pulmonary hypertension (maximum 5 doses) <input type="checkbox"/> Have cyanotic heart disease		
<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 <input type="checkbox"/> Neuromuscular condition compromising handling of respiratory tract secretions		
<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 03/2011  
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 November dose, or for the remainder of the present season if signed after November.