



MEDICAL JUSTIFICATION FORM FOR SYNAGIS – 2011-2012

Patient Name: _____ Patient's HPSM #: _____
Patient's Weight: _____ Patient's Date of Birth: _____

Patient's Gestational Age at Birth _____ Patient's Birth Weight _____
Synagis Dose (at 15 mg/kg): _____ Physician Name: _____
(PLEASE PRINT)

PLEASE CHECK EACH OF THE FOLLOWING THAT APPLIES:

- The infant/child is younger than 24 months of age with:
Chronic Lung Disease (CLD) and has required medical therapy (supplemental oxygen, bronchodilator, diuretic or corticosteroid therapy) for CLD within 6 months before the anticipated start of the RSV season (Nov-Dec 2011).
- The infant was born at 28 weeks of gestation or earlier, and the 2011 season is their first RSV season up to 12 months of age.
- The infant was born at 29 to 32 weeks gestation, and the 2011 season is their first RSV season up to 6 months of age.
- The infant was born between 32 and 35 weeks of gestation, is THREE months of age or younger and has one of the following risk factors: (Note: need ONE for authorization)
 - Child Care Attendance
 - School-Aged Siblings Under Five Years of Age
 (* High-risk infants should never be exposed to tobacco smoke)
- The infant is younger than 12 months with Congenital Heart Disease (CHD) and
 - is receiving medication to control congestive heart failure
 - has moderate to severe pulmonary hypertension
 - has cyanotic heart disease
 (Note: if up to 24 months of age with hemodynamically significant cyanotic or acyanotic CHD, can consider Rx)
- The child has severe immunodeficiencies and is under 24 months of age.
- The child has severe neuromuscular disease or congenital abnormality of the airways and is under 12 months of age.

Other additional information: _____

Person Completing Form: _____ Date of Completion: _____

IF ANY QUESTIONS, PLEASE CALL HPSM AT 650-616-2088

PHYSICIAN INFORMATION

Practice/Clinic Name: _____ Office Contact: _____
Address: _____ City _____
State _____ Zip Code: _____ License #: _____
Phone: _____ Fax #: _____ DEA #: _____

* Physician Signature: _____ Date: _____

Please Print Physician Name _____
