STATEMENT OF MEDICAL NECESSITY (SMN)

MAXOR® SPECIALTY

SYNAGIS® PALIVIZUMAB

1

Specialty Pharmacy Provider: **Maxor Specialty** Phone: **866-629-6779** Fax: **866-217-8034**

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
Address Street:	If yes, is sibling(s) referral being submitted simultaneously? ☐ Yes ☐ No
City: State: ZIP:	Sibling Names:

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):

4 ***PRESCRIBER INFORMATION***

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

5 ***CLNICAL INFORMATION***

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

Diagnosis Code(s):

CLINICAL INFORMATION: Birth weight: _____ ☐ 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? ☐ No ☐ Yes Agency name and Tax ID number: _____

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 AstraZeneca's Access 360, including employees, contractors, or affiliates of AstraZeneca, and healthcare plans for programs, dispensing pharmacy or other entities, for the purposes of treatment and payment support. If not already received, I give Access 360 permission to contact this patient to obtain Patient Authorization.

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