CLEAR FIELDS

SAVE FORM

SUBMIT

BC RSV IMMUNOPROPHYLAXIS PROGRAM APPLICATION FORM

The BC RSV ImmunoprophylaxisProgram only covers high risk children who meet the risk criteria established by the Program.

No child > 2 years of age at start of season is eligible.

Please COMPLETE THIS FORM ONLINE, save it and submit it to rsv@cw.bc.ca as an attachment to an email from a Health Authority (i.e., hospital) email account. Print a copy for your records.

To contact the RSV Program, please email rsv@cw.bc.ca, telephone 1-877-625-7888, or 604-875-2867 or fax 1-877-625-7555 or 604-875-2879

Section 1 - PATIENT INFORMATION

Last Name:	First Name:	PHN:	
Date of birth: (dd/mmm/yyyy)	Gest age at birth (w + d):	Date first discharged home: (dd/mmm/yyyy)	Age at time of request (mos):
☐ Male ☐ Female	Birth weight (g):	Birth weight percentile:	Current weight (g):
Parent / Guardian's First & Last Name:		Second Parent / Guardian's First & Last Name:	
Parent / Guardian phone numbers: Home Cell		City of Residence:	

Section 2 - REQUESTING PHYSICIAN

First and Last Name:	Person completing form (Name/Number):	
Physician Phone:	Physician Fax:	Physician Email:

Section 3 - COMMUNITY PHYSICIAN

First and Last Name:	Office Address or Institution Name:	
Phone:	Fax:	Physician Email:

Section 4 - PRODUCT DELIVERY INFORMATION

Hospital name for initial dose:	Hospital name for subsequent doses:
[For Pharmacy Use Only] Number of 50 mg vials to be shipped now:	[For Pharmacy Use Only] Number of 50 mg vials required for season:

Note: Dose of palivizumab is 15 mg/kg, as per Product Monograph

Approval

☐ Approved for 4 doses / season ☐ Approved for 3 doses / season ☐ Not approved

Adjudicator Name & Signature:	Date:

[For Pharmacy Use Only]

	Patient Initials:	PHSA / C&W PO #:	Provincial Ref. #:

Section 5 - PRE-APPROVED INDICATIONS

☐ Prem with BPD/CLD(O2 or CPAP more than 28d) AND ☐ DoB on or after 01Sep,2020 AND ☐ On continous O2 on or after 01May,2021

☐ GA at birth below 29w + 0 days AND ☐ discharged home on or after 01July,2021

☐ GA at birth 29w + 0d to 34w + 6d AND ☐ discharged home on or after 01Aug2021 AND ☐ risk factor score greater than 41 points*

☐ Tracheostomy / continuous home oxygen / ventilation on or after 01 Sep 2021 AND ☐ born on or after 01 Sep,2019

☐ Multiple of approved child AND ☐ qualifying twin qualifies under prematurity

☐ Hemodynamically significant CHD AND ☐ DoB on or after 01Sep,2020 (clinical details/name of supporting cardiologist below)

☐ Down Syndrome AND ☐ DoB on or after 01Feb,2021

Section 6 - INDICATIONS REQUIRING ADJUDICATION

☐ Progressive neuromuscular disease with inability to clear secretions AND ☐ DoB on or after 01 Sep,2019 (clinical details below)

☐ **Severe immunodeficiency (e.g., stem cell transplantation) AND ☐ DoB on or after 01 Sep,2019

☐ **Significant cardiopulmonary disability (pulmonary hypertension, pulmonary malformations, severe BPD, symptomatic CF, cardiac palliation, other) AND ☐ DoB on or after 01 Sep 2019 (clinical details below)

* The risk factors below will be important to facilitate adjudication in all borderline cases
** Summarize clinical course and level of disability in the space below or in separate sheet

Section 7 - ADDITIONAL CLINICAL INFORMATION REQUIRED (to be completed for ALL requests)

Risk factors present in this child at discharge:

Yes	No			
☐	☐	Will attend daycare regularly during first 3 months after discharge	22 pts	0
☐	☐	Discharged home in Oct or Nov,Dec 2021 or **Jan,2022**	20 pts	0
☐	☐	Discharged home in Sep,2021 or **Feb, 2022**	10 pts	0
☐	☐	Gestational age at birth 29 weeks + 0 days to 30 weeks + 6 days	10 pts	0
☐	☐	Other child younger than 5 years living at home (not including multiples of applicant)	14 pts	0
☐	☐	6 or more people at home (including applicant and multiples of applicant)	12 pts	0
☐	☐	Remote residence (Over 1 hour travel time or >100 km in Google maps to the nearest hospital)	10 pts	0
☐	☐	Girl not receiving breastmilk, or Boy (any)	8 pts	0
☐	☐	SGA (BW less than 10th percentile)	8 pts	0
☐	☐	2 or more smokers living at home	8 pts	0
			TOTAL:	0

Summarize clnical course to date with current/proposed Rx below or on separate sheet *Adjudicator comments will be e-mailed*

AUTHORIZATION FOR ADMINISTRATION OF PALIVIZUMAB AND FOLLOW-UP

The benefits and risks of this medication have been explained to parent/guardian and information provided on reducing the risk of respiratory infections. Parent/guardian ☐ CONSENTS ☐ DECLINES child receiving Palivizumab as per the BC RSV immunoprophylaxis program guidelines and to contact for follow-up.

Application form details and contact information are confirmed, and patient meets pre-approval criteria for funded prophylaxis.

If consent not obtained above, or adjudication required, a seperate authorization for treatment and follow up must be submitted following approval. (Telephone consent is ok).

Signature of health-care provider **Date**

Printed name **Contact number**