## 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 by 01 November, 2018 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:		PHN:		
Date of birth: (dd/mmm/yyyy)	Gest age at birth (w + d):		Date fi (dd/mmr	Date first discharged ho			Age at time of request (mos):	
☐ Male ☐ Female	Birth weight (g):		Birth w	Birth weight percentile:			Current weight (g):	
Parent / Guardian's First & Last Name:			Secon	Second Parent / Guardian's First & Last Name:				
Parent / Guardian phone numbers:			City of Residence:					
Home Cell								
Section 2 - REQUEST	ING PHYSICIA	N						
First and Last Name:				Person completing form (Name/Number):				
Physician Phone:		Physician Fax:			Physician Email:			
Continue 2 COMMUNITY DUVELCIAN								
Section 3 - COMMUNITY PHYSICIAN  First and Last Name:  Office Address or Institution Name:							itution Name:	
First and Last Name.				Office Address of Institution Name.				
Phone:		Fax:		Physician Ema		ian Em	ail:	
Section 4 PRODUCT	DELIVERY INF	ODMATION						
Section 4 - PRODUCT DELIVERY INFORMATION  Hospital name for initial dose:  Hospital name for subsequent doses:						dococ:		
Hospital name for initial dose:				Prospital flame for subsequent doses.				
[For Pharmacy Use Only]				[For Pharmacy Use Only]				
Number of 50 mg vials to be shipped now:  Number of 50 mg vials required for season:  Note: Dose of palivizumab is 15 mg/kg, as per Product Monograph								
Approval								
Approved for maximum 4 doses / season Approved for maximum 3 doses / season Not approved								
Adjudicator Name & Sig	pp.0100.10	Date:						
,								
[For Pharmacy Use O	nlvl							
		PHSA / C	HSA / 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	D1 Nov 2017 AND On continous O2 on or after 01 July 2018
$\square$ GA at birth below 29w + 0 days $\underline{AND}$ $\square$ discharged home on or after 01	Sep 2018
GA at birth 29w + 0d to 34w + 6d AND discharged home on or after 01 C	ct 2018 AND Trisk factors score greater than 41 points*
Tracheostomy / continuous home oxygen / ventilation on or after 01 No	ov 2018 AND  born on or after 01 Nov 2016
Multiple of approved child AND qualifying twin qualifies under pre-	naturity
☐ Hemodynamically significant CHD AND ☐ DoB on or after 01 Nov	2017 (clinical details/name of supporting cardiologist below)
Section 6 - INDICATIONS REQUIRING ADJUDICATION	
☐ Trisomy 21 without significant CHD AND ☐ discharged home on or	after 01 Sept 2018 <u>AND</u> ☐ risk factors*
Progressive neuromuscular disease with inability to clear secretion	s AND DoB on or after 01 Nov 2016 (clinical details below)
**Severe immunodeficiency (e.g., stem cell transplantation) AND	DoB on or after 01 Nov 2016
**Significant cardiopulmonary disability (pulmonary hypertension, paymptomatic CF, cardiac palliation, other) AND DoB on or aft	
* 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 and the second sec	
<ul><li>☐ Discharged home in Dec or Jan or Feb</li><li>☐ Discharged home in Nov or Mar</li></ul>	20 pts
Gestational age at birth 29 weeks + 0 days to 30 weeks + 6 days	10 pts ays 10 pts
Other child younger than 5 years living at home (not including	
☐ ☐ 6 or more people at home (including applicant and multiples of ☐ ☐ Remote residence	
(Over 1 hour travel time or >100 km in Google maps to the neare:	st hospital)
☐ ☐ Girl not receiving breastmilk, or Boy (any)	8 pts
☐ ☐ SGA (BW less than 10th percentile) ☐ ☐ 2 or more smokers living at home	8 pts 8 pts
2 of more smokers living at home	TOTAL:
Summarize clnical course to date with current/proposed Rx below or	
	on coporate enectricity.
AUTHORIZATION FOR ADMINISTRATION OF PALIVIZUMAB AND	
The benefits and risks of this medication have been explained to parent/guar	
- '	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 prophylavis
If consent not obtained above, or adjudication required, a seperate author	
submitted following approval. (Telephone consent is ok).	
Signature of health-care provider	<u>Date</u>
Printed name	Contact number

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