

# BC RSV IMMUNOPROPHYLAXIS PROGRAM APPLICATION FORM

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

No child > 2 years of age by 01 November, 2020 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):	
<input type="checkbox"/> Male <input type="checkbox"/> 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 <span style="margin-left: 100px;">Cell</span>			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 maximum 4 doses / season       Approved for maximum 3 doses / season       Not approved

Adjudicator Name & Signature:

Date:

## [For Pharmacy Use Only]

AbbVie Ref. #:	Patient Initials:	PHSA / C&W PO #:	Provincial Ref. #:
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### Section 5 - PRE-APPROVED INDICATIONS

- Prem with BPD/CLD(O2 or CPAP more than 28d) AND  DoB on or after 01 Nov 2019 AND  On continuous O2 on or after 01 July 2020
- GA at birth below 29w + 0 days AND  discharged home on or after 01 Sep 2020
- GA at birth 29w + 0d to 34w + 6d AND  discharged home on or after 01 Oct 2020 AND  risk factor score greater than 41 points\*
- Tracheostomy / continuous home oxygen / ventilation on or after 01 Nov 2020 AND  born on or after 01 Nov 2018
- Multiple of approved child AND  qualifying twin qualifies under prematurity
- Hemodynamically significant CHD AND  DoB on or after 01 Nov 2019 (clinical details/name of supporting cardiologist below)
- Down Syndrome AND  DoB on or after 01 April 2020

### Section 6 - INDICATIONS REQUIRING ADJUDICATION

- Progressive neuromuscular disease with inability to clear secretions AND  DoB on or after 01 Nov 2018 (clinical details below)
- \*\*Severe immunodeficiency (e.g., stem cell transplantation) AND  DoB on or after 01 Nov 2018
- \*\*Significant cardiopulmonary disability (pulmonary hypertension, pulmonary malformations, severe BPD, symptomatic CF, cardiac palliation, other) AND  DoB on or after 01 Nov 2018 (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		
<input type="checkbox"/>	<input type="checkbox"/>	Will attend daycare regularly during first 3 months after discharge	22 pts
<input type="checkbox"/>	<input type="checkbox"/>	Discharged home in Dec or Jan or Feb	20 pts
<input type="checkbox"/>	<input type="checkbox"/>	Discharged home in Nov or Mar	10 pts
<input type="checkbox"/>	<input type="checkbox"/>	Gestational age at birth 29 weeks + 0 days to 30 weeks + 6 days	10 pts
<input type="checkbox"/>	<input type="checkbox"/>	Other child younger than 5 years living at home (not including multiples of applicant)	14 pts
<input type="checkbox"/>	<input type="checkbox"/>	6 or more people at home (including applicant and multiples of applicant)	12 pts
<input type="checkbox"/>	<input type="checkbox"/>	Remote residence (Over 1 hour travel time or >100 km in Google maps to the nearest hospital)	10 pts
<input type="checkbox"/>	<input type="checkbox"/>	Girl not receiving breastmilk, or Boy (any)	8 pts
<input type="checkbox"/>	<input type="checkbox"/>	SGA (BW less than 10th percentile)	8 pts
<input type="checkbox"/>	<input type="checkbox"/>	2 or more smokers living at home	8 pts
			TOTAL:

Summarize clinical 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 separate 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