NOVA SCOTIA RSV PROPHYLAXIS REQUEST FORM 2022-2023

(To be completed if the child lives outside of Halifax (formerly the Halifax Regional Municipality)

Date of Request (YYYY/MMM/DD): ____/ ____/ _____ PATIENT REFERENCE NO _____

PATIENT INFORMATION

Patient's Province of Residence: _____

Patient Initials: First Initial _____

Last Initial _____

☐Male ☐Female

Date of Birth _____/_____/_____
yyyy MMM dd

Current Weight in Grams: _____

Please indicate if infant is in a set of:
☐Twins ☐Triplets ☐ Quadruplets

☐ Parent/Guardian informed that the child's "non-identifying" demographic information will be shared with AstraZeneca Canada Inc. in Mississauga, Ontario for the purpose of obtaining the vaccine. The Nova Scotia Personal Health Information Act requires consent for release of any personal health information including demographics.

Document initials of patient followed by the numerical order:

(e.g. For Triplets enter as AB # 1, BB # 2, CB # 3)

|____|____|____|____|____|

Defined Nova Scotia RSV Season is January to May
(ie the highest risk season when the annual RSV outbreak occurs).

☐ Initial Dose ☐Subsequent Dose

Dosing schedule: **Palivizumab (Synagis**)
15 mg/kg/dose intramuscularly once monthly beginning December 2022 through April 2023.
Please order only one dose at a time for each patient

Total # of 100 mg vials requested: _____

Total # of 50 mg vials requested: _____

PHYSICIAN/NURSE PRACTIONER INFORMATION

(All fields mandatory)

Last Name : _____

First Name : _____

Institution Name: _____

Address: _____

City:_____ Province:_____

Postal Code: _____

Nova Scotia Health Authority Zone: _____

Telephone: (____) _____Ext: _____

Fax: (____) _____

Provincial Medical License No: _____

Certified Medical Specialty: _____

Type of practice:
☐Community ☐Hospital

CRITERIA FOR CONSIDERATION

OTHER CATEGORY

☐Specific Medical Illness: Requires the following documentation before request can be sent for medical consultation:

- Letter from requesting physician providing medical justification for request and
- Letter from infectious disease specialist or respirologist supporting the request
- Examples of children who could be considered high risk: severe combined immunodeficiency syndrome, severe hypotonia preventing adequate clearance of respiratory secretions, or severe chronic lung disease not due to prematurity.

PRODUCT DELIVERY INFORMATION

Shipping address (First dose):

Shipping address (Subsequent doses, if different from above):

It is strongly recommended that Synagis® be delivered to a hospital pharmacy due to strict storage requirements. Palivizumab is sold on a **"non-returnable"** and **"non-refundable"** basis.

Storage will be at: ☐Pharmacy ☐Physician Office
☐Public Health

Patient Initials:

|____|____|____|____|____|

PATIENT REFERENCE NO _____

INDICATION FOR USE Date of Birth (YYYY/MMM/DD): ____ / ____ / ____ ☐Male ☐Female

(Please select appropriate indication)

☐Infants born prematurely at ≤ 30 weeks, 0 days gestation and aged ≤ 6 months WITH bronchopulmonary dysplasia/chronic lung disease

i.e. must be born on or after June 1, 2022.

☐Infants born prematurely at ≤ 30 weeks, 0 days gestation and aged ≤ 6 months WITHOUT bronchopulmonary dysplasia/chronic lung disease
i.e. must be born on or after June 1, 2022.

Please record the EXACT gestational age at birth of this infant:

weeks _____days _____

☐Children < 12 months of age with hemodynamically significant heart disease.

☐Children < 24 months of age with bronchopulmonary dysplasia/chronic lung disease AND who have required oxygen and/or medical therapy within the 6 months preceding the RSV season (June-November 2022).

Age: ☐≤ 1 year old ☐Between 1 and 2 years old

IMPORTANT

Please fax or email all of this completed request form to: AstraZeneca's Synagis Care Coordinator at 1-833-397-2357 OR enrollment@AZInfantPSP.ca

All RSV request forms submitted to AstraZeneca's Synagis Care Coordinator will be faxed back to the requesting physician's fax number (entered on forms) and also to the IWK Health at 902-470-7846.

Form completed by : _____