NOVA SCOTIA RSV PROPHYLAXIS REQUEST FORM 2024-2025

(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's Province of Residence: Patient Initials: First Initial	Defined Nova Scotia RSV Season is January to May (ie the highest risk season when the annual RSV outbreak occurs).
Last Initial Male DFemale	□ Nirsevimab Dose
Date of Birth ////////////////////////////////////	Dosing instructions: Beyfortus[™] (Nirsevimab) Nirsevimab is administered as a one-time, fixed dose of 50mg (infants <5kg), or 100mg (infants ≥5 kg).
Current Weight in Grams: Please indicate if infant is in a set of:	Total # of 100 mg vials requested:
□Twins □Triplets □ Quadruplets	Total # of 50 mg vials requested:
Document initials of patient followed by the numerical order:	** Children who remain vulnerable to severe RSV disease entering their second RSV season. The recommended dose of Beyfortus [™] is a single dose
(e.g. For Triplets enter as AB # 1, BB # 2, CB # 3)	of 200mg given as two intramuscular injections (2 x 100mg)
HYSICIAN/NURSE PRACTIONER INFORMATION	
(All fields mandatory) Last Name :	Nova Scotia Health Authority Zone:
First Name :	Telephone: () Ext:

 Institution Name:
 Fax: (__)_____

 Address:
 Provincial Medical License No: ______

 City:
 Province:
 Certified Medical Specialty: ______

 Postal Code:
 Type of practice:

 Community
 Hospital

C	CRITERIA FOR CONSIDERATION	PRODUCT DELIVERY INFORMATION
	OTHER CATEGORY	Shipping address:
	 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. 	

IDICATION FOR USEDate of Birth (YYYY/MMM/E(Please select appropriate indication) \Box Infants born prematurely at ≤ 32 weeks,	DD): / /
\Box Infants born prematurely at \leq 32 weeks, \Box C	
1	hildren < 12 months of age with hemodynamically ignificant heart disease.
0 days gestation and aged ≤ 6 monthsWITHOUTdybronchopulmonary dysplasia/chronic lung diseaseoxi.e. must be born on or after June 1, 2024.Age	hildren < 24 months of age with bronchopulmonary splasia/chronic lung disease AND who have required sygen and/or medical therapy within the 6 months preceding the RSV season (June-November 2024). e: $\Box \le 1$ year old \Box Between 1 and 2 years old
Please record the EXACT gestational age at birth of this infant: weeksdays	

Please fax the completed request form to the IWK Health RSV Prevention Program at 902-470-7846 ATTN: RSV Monitoring Nurse.

Form completed by : _____