Beneficiary Full Name: _____ Sponsor's SSN: _____-_____-_____

Date of Birth: _____ Beneficiary State of Residence: _____

Dear Provider,

Please complete the letter of attestation below and return as indicated on the additional information request letter.

TRICARE authorizes coverage for palivizumab (Synagis®) in limited circumstances. Coverage is limited to one dose per month up to a maximum of five consecutive doses. Respiratory syncytial virus (RSV) season begins September 15th and ends May 30th.

Has the beneficiary received any other RSV vaccine [i.e. Abrysvo® (respiratory syncytial virus vaccine), Beyfortus™ (nirsevimab)]?

☐ Yes
If yes, please provide the date of the RSV vaccine given_____

☐ No

MEDICAL HISTORY

In order for Synagis to be approved, the provider must attest the beneficiary meets one or more of the following criteria:

Prematurity

☐ preterm infant born at less than 29 weeks, 0 days gestational age and less than 12 months of age at the start of the RSV season

Premature with chronic lung disease

☐ preterm infant born at less than 32 weeks gestation with chronic lung disease

- ☐ less than 12 months of age and has chronic lung disease that requires greater than 21 percent oxygen for at least the first 28 days after birth, or
- ☐ greater than 12 months of age and continues to require medical support for chronic lung disease during the 6-month period before the start of the RSV season, *and* with one of the following:
  - ☐ chronic corticosteroid therapy,
  - ☐ diuretic therapy or
  - ☐ supplemental oxygen

Hemodynamically significant congenital heart disease

☐ infant 12 months or younger with hemodynamically significant congenital heart disease and any of the following:

- ☐ acyanotic heart disease that requires medication to control congestive heart failure *and* will require cardiac surgical procedures
- ☐ moderate to severe pulmonary hypertension
- ☐ cyanotic heart disease when ordered by or recommended by a pediatric cardiologist
- ☐ recipient of a cardiac transplant during the RSV season

(Continued on next page)

Anatomic pulmonary abnormalities or neuromuscular disorder

☐ infant 12 months or younger with anatomic pulmonary abnormalities or neuromuscular disorder with impaired ability to clear secretions from upper airway because of ineffective cough

Immunocompromised

☐ infant or child, 24 months or younger who is immunocompromised

☐ Please provide details (chemotherapy, organ transplant, etc.): _____

_____

Cystic Fibrosis

☐ infant 12 months or younger diagnosed with cystic fibrosis who has manifestations of chronic lung disease and or nutritional compromise

☐ child 24 months or younger diagnosed with cystic fibrosis with manifestations of severe lung disease as evidenced by previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable, or weight for length less than the 10th percentile.

Other

☐ Please explain: _____

_____

_____

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information: _____

Physician's printed name and title:_____

TIN: _____

Signature: _____ Date: _____

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