RSV IMMUNOPROPHYLAXIS PROGRAM APPLICATION FORM 2024-2025

The Yukon RSV Immunoprophylaxis Program only covers high risk children who meet the risk criteria established by the Program. No child older than 2 years of age at the start of the season is eligible. **For 2024-2025, the start of RSV season is considered to be November 1, 2024; facilities are eligible to administer doses as soon as available to order (end of October 2024).**

For the 2024/2025 RSV season, the Yukon RSV Immunoprophylaxis Program will be transitioning from Palivizumab (Synagis) to Nirsevimab (BEYFORTUS). Nirsevimab is the preferred product; however, infants may be started on Palivizumab in its absence. Clients should be made aware of the transition this season and the potential to receive one or both products.

Please COMPLETE THIS FORM, save it and submit it to immunizationprogram@yukon.ca as an attachment. If you have further questions regarding the RSV program, please contact immunizationprogram@yukon.ca or call 867-334-7862.

SECTION 1 – PATIENT INFORMATION

Last Name:	First Name:	YHCIP Number:	
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):
☐Male ☐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 number:		City of residence:	

SECTION 2 – REQUESTING PHYSICIAN

First and Last Name:		Facility:
Phone:	Fax:	Email:

SECTION 3 – PRIMARY CARE PHYSICIAN INFORMATION *(if different than above)*

First and Last Name:		Facility:
Phone:	Fax:	Email:

SECTION 3 - PRODUCT DELIVERY INFORMATION

Name of healthcare facility for Palivizumab or Nirsevimab administration:	(Yukon Immunization Program Use Only) Number of vials to be shipped now: Number of vials required for the season:

SECTION 4 – APPROVAL YUKON IMMUNIZATION PROGRAM / CMOH

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☐ Approved ☐ Not Approved	Requisition Number (YIP use only): _____________
Immunization Program Manager Signature: ____	Date: ____
Adjudicator Signature (if required): ____	Date: ____

Section 5 – PRE-APPROVED INDICATIONS

- ☐ All premature infants (i.e., born less than 37 wGA)
- ☐ Chronic lung disease, including bronchopulmonary dysplasia, requiring ongoing assisted ventilation, oxygen therapy or chronic medical therapy in the 6 months prior to the start of the RSV season
- ☐ Cystic fibrosis with respiratory involvement and/or growth delay
- ☐ Hemodynamically significant chronic cardiac disease
- ☐ Severe congenital airway anomalies impairing clearing of respiratory secretions
- ☐ Severe immunodeficiency
- ☐ Neuromuscular disease impairing clearing of respiratory secretions
- ☐ Down Syndrome

Section 7 – CLINICAL INFORMATION REQUIRED (must be completed for ALL requests)

Risk factors present in this child at discharge (circle):

YES/ NO	Will attend daycare regularly during first 3 months after discharge	**22 pts**
YES/ NO	Discharged home 5-16 weeks of season	**20 pts**
YES/ NO	Discharged home in weeks 1-4 or weeks 17-20 of season	**10 pts**
YES/ NO	Gestational age at birth 29 weeks + 0 days to 30 weeks + 6 days	**10 pts**
YES/ NO	Other child < 5 years living at home (not including multiples of applicant)	**14 pts**
YES/ NO	6 or more people at home (including applicant and multiples of applicant)	**12 pts**
YES/ NO	Remote community (Yukon is considered remote)	**10 pts**
YES/ NO	Girl not receiving breastmilk, or Boy (any)	**8 pts**
YES/ NO	SGA (BW less than 10th percentile)	**8 pts**
YES/ NO	2 or more smokers living at home	**8 pts**
	TOTAL:	

Summarize clinical course to date with current/proposed Rx below or on separate sheet. Include any relevant treatment documents with this application.

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AUTHORIZATION FOR ADMINISTRATION OF PALIVIZUMAB AND/OR NIRSEVIMAB AND FOLLOW-UP

The benefits and risks of these biological products have been explained to parent/guardian and information provided on reducing the risk of respiratory infections.

Parent/ guardian ☐ CONSENTS ☐ DECLINES child receiving Palivizumab and/or Nirsevimab as per the Yukon 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, 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:** ______