MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

SYNAGIS PRIOR AUTHORIZATION FORM

RETURN TO: ATTN: DRUG PRIOR AUTHORIZATION
MO HEALTHNET DIVISION
PO BOX 4900
JEFFERSON CITY, MO 65102-4900

PLEASE PRINT OR TYPE. ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL NOT BE PROCESSED.
PHONE: (800) 392-8030 FAX: (573) 636-6470

Participant Name		Participant MO HealthNet Number
Date of Birth	Gestational Age Weeks_________ and Days_________ (Both are required)	
Birth Weight kg	Current Weight kg	Date of Current Weight

Number of doses requested? ____________________________ What is the start date? ____________________

Is this the initial dose for RSV season? ☐ Yes ☐ No

If no, what was the date and setting (i.e., hospital, physician office) of the previous dose(s)? ______________________________

Please mark all criteria that apply:

☐ **Chronic Lung Disease with ICD-10 code:** ____

- Participant aged < 12 months and born < 32 weeks gestation with chronic lung disease and required > 21% oxygen for 28 days following birth and currently requiring medical therapy. Specify medical therapy in list below.
- Participant aged < 24 months and born < 32 weeks gestation with chronic lung disease and required > 21% oxygen for 28 days following birth and required medical therapy for the past 6 months. Specify medical therapy in list below.

☐ Oxygen — % required at birth:______, # of days required at birth: ______, Most recent date administered: _______________

☐ Corticosteroids — Most recent medication and date administered _______________________________________

☐ Bronchodilators — Most recent medication and date administered _______________________________________

☐ Diuretics — Most recent medication and date administered _______________________________________

☐ Ventilator — Start Date _______________

☐ **Prematurity:**

☐ Participant aged ≤ 12 months at start of therapy and born ≤ 28 weeks gestation.
☐ Participant aged ≤ 6 months at start of therapy and born between 29 to 32 weeks gestation.
☐ Participant aged ≤ 3 months at start of therapy and born between 32 to 35 weeks gestation who attends childcare or with sibling(s) < 5 years old.

☐ **Congenital abnormality of the airway or neuromuscular disease** that impairs the ability to clear secretions for participants <12 months of age with ICD-10 code: ____

☐ List medications that support diagnosis: ____

☐ **Congenital Heart Disease:**

- Participant is ≤ 24 months at start of therapy and has hemodynamically significant cyanotic or acyanotic congenital heart disease. Please list ICD-10 code and medications used in treatment next to type of condition.

☐ Congestive heart failure: ____

☐ Moderate to severe pulmonary hypertension: ____

☐ Cyanotic congenital heart disease: ____

☐ **Severe Immunodeficiency or Recent Transplant:**

- Participant is ≤ 24 months at start of therapy and has severe immunodeficiency.

☐ Describe: ____

☐ List medications that support diagnosis: ____

Attach documentation as necessary.

Prescriber name and specialty		Prescriber Provider NPI
Prescriber Telephone Number	Prescriber Fax Number	Prescriber Other contact info:
Administering provider name (if different from prescriber)		Administering Provider NPI
Name, title and credentials of person completing form		
Telephone Number of person completing form	Fax Number of person completing form	Other contact info of person completing form:
Signature of person completing form		Date