aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-296-0323 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at
www.aetnabetterhealth.com/newjersey/providers/pharmacy

Synagis
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs, and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone		Office Fax:

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
Are there any contraindications to formulary medications? (If yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
Is this a request for an increase OR decrease in dose OR quantity of previously approved medication?	☐ Yes	☐ No		
Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	What is the diagnosis ICD-10 Code?	Diagnosis:		
If applicable, what medication(s) has member tried for diagnosis?				
Directions for Use:	Strength:	Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:	

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Criteria						
Has the member previously received Beyfortus during the same respiratory syncytial virus (RSV) season?					☐ Yes	☐ No
Is the requested medication being used to prevent serious lower respiratory tract disease caused by RSV?					☐ Yes	☐ No
Is this an off-season request for the requested medication?					☐ Yes	☐ No
Has the member received any doses of this medication this RSV season?	☐ Yes	☐ No	If yes, please provide number of doses received: _____			
☐ **Prematurity**						
Is Gestational Age < 29 weeks, 0 days?	☐ Yes	☐ No	Is member less than 12 months of age at the start of RSV season?		☐ Yes	☐ No

☐ **Chronic Lung Disease of Prematurity**					
Is Gestational Age < 32 weeks, 0 days?	☐ Yes	☐ No	Did the member require > 21% oxygen for at least the first 28 days after birth?	☐ Yes	☐ No
Does the member meet one of the following:	☐ Member's chronological is < 12 months of age at the start of RSV season ☐ Member's chronological age at the start of RSV season is <24 months AND they continue to require medical support (for example, chronic corticosteroids, diuretic therapy, supplemental oxygen) during the 6-month period prior to the start of the RSV season				

☐ **Congenital Heart Disease**		
Is Congenital heart disease (CHD) hemodynamically significant?	☐ Yes	☐ No
Does the member meet one of the following:	☐ Member's chronological age is < 12 months of age at the start of RSV season ☐ Member's chronological age at the start of RSV season is between 12 to 24 months AND the member will be undergoing cardiac transplantation during the RSV season.	

☐ **Congenital Airway Abnormality**					
Is member's chronological age less than 12 months of age at the start of RSV season?	☐ Yes	☐ No	Does condition compromise handling of respiratory secretions?	☐ Yes	☐ No

☐ **Neuromuscular Condition**					
Is member's chronological age less than 12 months of age at the start of RSV season?	☐ Yes	☐ No	Does the condition compromise handling of respiratory secretions?	☐ Yes	☐ No
☐ **Immunocompromised Children**					
Is member's chronological age less than 24 months of age at the start of RSV season?	☐ Yes	☐ No	Is member profoundly immunocompromised during RSV season (for example, SCID, stem cell transplant, bone marrow transplant)?	☐ Yes	☐ No

☐ **Cystic Fibrosis**			
Is member's chronological age less than 12 months of age at the start of the RSV season AND has evidence of chronic lung disease OR nutritional compromise in 1st year of life?	☐ Yes	☐ No	☐ N/A
Is member's chronological age between 12 to 24 months of age or younger and the member has manifestations of lung disease (e.g., hospitalizations for pulmonary exacerbations) or weight for length less than the 10th percentile?	☐ Yes	☐ No	☐ N/A
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.			

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 855-232-3596 to check the status of a request.