



Fax completed prior authorization request form to 877-270-3298 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

Aetna Better Health®

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/maryland/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:	Height:
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
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):		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> New request <input type="checkbox"/> Continuation of therapy request	
Is this a request for an increase OR decrease in dose OR quantity of previously approved medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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			
<input type="checkbox"/> Standard – (24 hours)	<input type="checkbox"/> 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the requested medication being used to prevent serious lower respiratory tract disease caused by RSV?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this an off-season request for the requested medication?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the member received any doses of this medication this RSV season?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please provide number of doses received: _____
According to the CDC National Respiratory and Enteric Virus Surveillance System (NREVSS), is the RSV activity greater than or equal to 10% (with rapid antigen testing) or greater than or equal to 3% (with real-time polymerase chain reaction (PCR) test) for the requested region or state within 2 weeks of the intended dose?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Prematurity			

Is Gestational Age < 29 weeks, 0 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member less than 12 months of age at the start of RSV season?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Chronic Lung Disease of Prematurity						
Is Gestational Age < 32 weeks, 0 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did the member require > 21% oxygen for at least the first 28 days after birth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the member meet one of the following:	<input type="checkbox"/> Member's chronological is < 12 months of age at the start of RSV season <input type="checkbox"/> 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					
<input type="checkbox"/> Congenital Heart Disease						
Is Congenital heart disease (CHD) hemodynamically significant?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the member meet one of the following:	<input type="checkbox"/> Member's chronological age is < 12 months of age at the start of RSV season <input type="checkbox"/> 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.					
<input type="checkbox"/> Congenital Airway Abnormality						
Is member's chronological age less than 12 months of age at the start of RSV season?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does condition compromise handling of respiratory secretions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Neuromuscular Condition						
Is member's chronological age less than 12 months of age at the start of RSV season?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the condition compromise handling of respiratory secretions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Immunocompromised Children						
Is member's chronological age less than 24 months of age at the start of RSV season?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member profoundly immunocompromised during RSV season (for example, SCID, stem cell transplant, bone marrow transplant)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> 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 1 st year of life?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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 10 th percentile?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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 866-827-2710 to check the status of a request.