aetna™

Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 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 https://www.aetnabetterhealth.com/Illinois-medicaid

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					
☐ **Preterm Infants without Chronic Lung Disease**					
Is Gestational Age < 29 weeks 0 days?	☐ Yes	☐ No	Is member 12 months of age or younger at start of RSV season?	☐ Yes	☐ No
☐ **Preterm Infants with Chronic Lung Disease**					
Is Gestational Age < 32 weeks 0 days?	☐ Yes	☐ No			
Is member < 12 months of age at start of RSV season AND required > 21% oxygen for more than 28 days after birth?	☐ Yes	☐ No	☐ N/A		
Is member between 12 and 24 months of age at start of RSV season AND continues to require medical support (for example, supplemental oxygen, chronic systemic corticosteroid therapy, diuretic therapy, or bronchodilator therapy) within 6 months of start of RSV season?	☐ Yes	☐ No	☐ N/A		
☐ **Infants with Hemodynamically Significant Congenital Heart Disease**					
Is member between 12 and 24 months of age at start of RSV season AND has undergone cardiac	☐ Yes	☐ No			

transplantation during RSV season?						
Member is less than 12 months of age at start of RSV season AND meets ONE of the following (check one):						
☐ Diagnosis is of acyanotic heart disease requiring cardiac surgery AND currently receiving medication to control heart failure		☐ Diagnosis is of cyanotic heart disease AND prophylaxis is recommended by Pediatric Cardiologist		☐ Diagnosis is of moderate to severe pulmonary hypertension		
☐ **Children with Anatomic Pulmonary Abnormalities or Neuromuscular Disorder**						
Is member 12 months of age or younger at start of RSV season?	☐ Yes	☐ No	Does disease or congenital anomaly impair ability to clear secretions from upper airway due to ineffective cough	☐ Yes	☐ No	
☐ **Immunocompromised Children**						
Is member 24 months of age or younger at start of RSV season?	☐ Yes	☐ No	Is child profoundly immunocompromised during RSV season?	☐ Yes	☐ No	
☐ **Children with Cystic Fibrosis**						
Is member 12 months of age or younger AND has clinical evidence of chronic lung disease AND/OR nutritional compromise in 1st year of life?	☐ Yes	☐ No	☐ N/A			
Is member 24 months of age or younger with manifestations of severe lung disease, such as previous hospitalization for pulmonary exacerbation in 1st year of life OR abnormalities on chest radiography OR chest computed tomography that persist when stable?	☐ Yes	☐ No	☐ N/A			
Is member 24 months of age or younger with weight for length <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 866-329-4701 to check the status of a request.