aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-799-2551 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/michigan/providers/medicaid/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		
Medication request is NOT for an FDA approved, or compendia supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No
Directions for Use:	Strength:	Dosage Form:
	Quantity: / Day Supply:	Duration of Therapy/Use:
What medication(s) has member tried and failed for this diagnosis? Please specify:		

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 Information		
Has Synagis been prescribed for prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV)	☐ Yes	☐ No
Does the member have a history of severe prior reaction to palivizumab or any component of the formulation?	☐ Yes	☐ No
Will discontinuation of therapy be considered if the member is noncompliant with medical or pharmacologic therapy?	☐ Yes	☐ No
Will monthly doses of Synagis be discontinued if the member experiences a breakthrough respiratory syncytial virus (RSV) hospitalization?	☐ Yes	☐ No
Has documentation been submitted (eg, labs, medical record, special studies) supporting the need for the requested drug?	☐ Yes	☐ Np
Is the request for more than 5 doses total?	☐ Yes	☐ No
Is the member undergoing a surgical procedure that involves cardiopulmonary bypass during the respiratory syncytial virus (RSV) season?	☐ Yes	☐ No

☐ **Prematurity**					
Will the member be younger than 12 months of age at the start of RSV season?	☐ Yes	☐ No	Was the member born BEFORE 29 weeks 0 days gestation?	☐ Yes	☐ No
☐ **Chronic Lung Disease**					
Is the member a preterm infant younger than 12 months of age who developed chronic lung disease of prematurity (defined as gestational age less than 32 weeks, 0 days)?	☐ Yes	☐ No	Did the member require >21% oxygen for at least the first 28 days after birth?	☐ Yes	☐ No
Is the member an infant, 12 to 24 months of age, who developed chronic lung disease of prematurity (defined as gestational age)?	☐ Yes	☐ No	Does the member require medical support (chronic corticosteroid therapy, diuretic therapy, supplemental oxygen or bronchodilator therapy) within 6 months of the start of RSV season?	☐ Yes	☐ No
☐ **Heart Disease**					
Is the member an infant, 12 months of age or younger, with hemodynamically significant congenital heart disease?				☐ Yes	☐ No
Check option(s) that apply:	☐ Member has acyanotic heart disease and is receiving medication to control congestive heart failure (documentation required) and will require cardiac surgical procedures.		☐ Member has moderate to severe pulmonary hypertension	☐ Member has cyanotic heart disease (if recommended by pediatric cardiologist).	
Is the member younger than 24 months and will undergo cardiac transplantation during the RSV season?				☐ Yes	☐ No
☐ **Neuromuscular disease, congenital airway anomaly or pulmonary abnormality**					
Is the member an infant under 12 months of age with neuromuscular disease, congenital anomalies of the airway or pulmonary abnormalities that impair the ability to clear secretions from the upper airway because of ineffective cough?				☐ Yes	☐ No
☐ **Immunocompromised**					
Is the member age 24 months or younger, who is profoundly immunocompromised because of chemotherapy or other conditions during the RSV season?				☐ Yes	☐ No
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 855-300-5528 to check the status of a request.