Synagis

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. Has the patient previously received Beyfortus during the same RSV season?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Is the requested drug being used to prevent serious lower respiratory tract disease caused by RSV?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Does the patient have a diagnosis of prematurity (defined as gestational age less than or equal to 28 weeks, 6 days)?
❒ Yes, *Continue to 5*
❒ No, *Continue to 4*

4. What is the diagnosis?
❒ Chronic lung disease of prematurity, *Continue to 7*
❒ Congenital heart disease (CHD), *Continue to 13*
❒ Congenital abnormality of the airway, *Continue to 16*
❒ Neuromuscular condition, *Continue to 16*
❒ Immunocompromised child, *Continue to 18*
❒ Cystic fibrosis, *Continue to 20*
❒ Other, please specify. _____, *No further questions*

5. What was the patient's gestational age?
❒ Less than or equal to 28 weeks, 6 days, *Continue to 6*
❒ Greater than or equal to 29 weeks, 0 days, *Continue to 6*

6. What is the patient's chronological age at the start of the RSV season?
❒ Less than 12 months of age, *Continue to 23*
❒ Greater than or equal to 12 months of age, *Continue to 23*

7. What was the patient's gestational age?
❒ Less than or equal to 31 weeks, 6 days, *Continue to 8*
❒ Greater than or equal to 32 weeks, 0 days, *Continue to 8*

8. Does/Did the patient require greater than 21% oxygen for at least the first 28 days after birth?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. What is the patient's chronological age at the start of RSV season?
❒ Less than 12 months of age, *Continue to 10*
❒ Greater than or equal to 12 months to less than 24 months of age, *Continue to 11*
❒ Greater than or equal to 24 months of age, *No further questions*

10. Did the patient receive the requested drug during the previous RSV season?
❒ Yes, *Continue to 11*
❒ No, *Continue to 23*

11. Does the patient continue to require medical support during the 6-month period prior to the start of the current RSV season?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. What is the treatment?

❒ Supplemental oxygen, *Continue to 23*

❒ Diuretic therapy, *Continue to 23*

❒ Chronic corticosteroids, *Continue to 23*

❒ Other, please specify. _____, *Continue to 23*

13. Is the CHD hemodynamically significant?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. What is the patient's chronological age at the start of RSV season?

❒ Less than 12 months of age, *Continue to 23*

❒ Greater than or equal to 12 months to less than 24 months of age, *Continue to 15*

❒ Greater than or equal to 24 months of age, *No further questions*

15. Is there a possibility that the patient will be undergoing cardiac transplantation during RSV season?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

16. Does the patient's condition compromise handling of respiratory secretions?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. What is the patient's chronological age at the start of the RSV season?

❒ Less than 12 months of age, *Continue to 23*

❒ Greater than or equal to 12 months of age, *Continue to 23*

18. Is the patient profoundly immunocompromised (e.g., severe combined immunodeficiency [SCID], stem cell transplant, bone marrow transplant)?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. What is the patient's chronological age at the start of the RSV season?

❒ Less than 24 months of age, *Continue to 23*

❒ Greater than or equal to 24 months of age, *Continue to 23*

20. What is the patient's chronological age at the start of the RSV season?

❒ Less than 12 months of age, *Continue to 21*

❒ Greater than or equal to 12 months of age to less than 24 months of age, *Continue to 22*

❒ Greater than or equal to 24 months of age, *No further questions*

21. Does the patient have evidence of chronic lung disease (CLD) or nutritional compromise?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

22. Does the patient have manifestations of lung disease (e.g., hospitalizations for pulmonary exacerbations) or weight for length less than the 10th percentile?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Is this an off-season request for the requested drug?
❒ Yes, *Continue to 25*
❒ No, *Continue to 24*

24. How many doses of the requested drug has the patient received this RSV season?
_____doses, *No further questions*

25. According to the CDC National Respiratory and Enteric Virus Surveillance System (NREVSS), is the RSV activity 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?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. How many doses of the requested drug has the patient received this RSV season?
_____doses, *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**