REALRx

PRIOR AUTHORIZATION REQUEST FORM
BEYFORTUS™

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Product being requested: ☐ Beyfortus™ (nirsevimab-alip)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Is the member less than 8 months of age born during or entering their first Respiratory Syncytial Virus (RSV) season?	☐	☐	If yes, prior authorization is NOT required.
3. Is the member 8-19 months of age entering their second RSV season?	☐	☐	**Please provide documentation**
4. Does the member have chronic lung disease of prematurity, defined as gestational age < 32 weeks AND required medical support (chronic corticosteroid therapy, diuretic therapy or supplemental oxygen) any time during the 6-month period before the start of the second RSV season?	☐	☐	**Please provide documentation**
5. Is the member expected to be profoundly immunocompromised during the current RSV season?	☐	☐	**Please provide documentation**
6. Does the member have cystic fibrosis with manifestations of severe lung disease (i.e., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable) or have a weight-for-length < 10th percentile?	☐	☐	**Please provide documentation**
7. Will the member be undergoing cardiac surgery with cardiopulmonary bypass? *Date of surgery:____* *Date of most recent Beyfortus dose:_____*	☐	☐	**Please provide documentation**

Additional information:
Physician's Signature:

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Policy: PHARM- 154
Origination Date: 09/12/2023
Reviewed/Revised Date: 10/03/2023
Next Review Date: 10/03/2024
Current Effective Date: 10/07/2023