

PRIOR AUTHORIZATION REQUEST FORM

BEYFORTUS™

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

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: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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: _____

Questions	Yes	No	Comments/Notes
1. Is the member less than 8 months of age born during or entering their first Respiratory Syncytial Virus (RSV) season?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, prior authorization is NOT required.
2. Is the member 8-19 months of age entering their second RSV season?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. 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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the member expected to be profoundly immunocompromised during the current RSV season?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. 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 < 10 th percentile?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Will the member be undergoing cardiac surgery with cardiopulmonary bypass? <i>Date of surgery:</i> _____ <i>Date of most recent Beyfortus dose:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

Additional information:

Physician 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
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