

Fax this completed form to:  
 La Medicaid Rx PA Operations  
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 Monroe, LA 71201-3765  
 FAX 866-797-2329

**State of Louisiana**  
**Department of Health and Hospitals**  
 Bureau of Health Services Financing  
**Palivizumab Clinical Pre-Authorization Form**  
**2015-2016 RSV Season**

Form: Rx PA02  
 Revised: 10/08/2015  
 VOICE PHONE 866-730-4357

Request must be faxed. Please type or print legibly. Incomplete forms will not be approved. Date of Request \_\_\_\_\_

<b>Prescribing Provider Information</b>	<b>Recipient Information</b>	
Name (Last, First)	Name (Last, First)	
LA Medicaid Prescribing Provider Number / NPI	LA Medicaid CCN or Recipient Number	
Call-Back Phone Number (include area code)	Date of Birth (mm/dd/yy)	Gestational Age (weeks/days)
FAX Number (include area code)	Recipient Current Weight _____ kg as of _____ (mm/dd/yy)	
Drug and Strength Requested	Diagnosis Code(s) (ICD-10-CM) to Justify Palivizumab Use	
Office Contact Name	EPSDT Support Coordinator (Name / Address) (optional)	

**Does the patient have additional insurance coverage (TPL)?** \_\_\_ Yes \_\_\_ No **If Yes, please contact TPL to determine coverage for this drug.**

**Check the applicable age/condition.** For chronic lung disease (CLD) of prematurity/congenital heart disease (CHD), attach supporting documentation (i.e. progress notes, discharge notes, pediatric cardiologist consult notes and/or chart notes) for any submitted ICD-10 diagnosis code(s). Please refer to the Palivizumab Criteria ICD-10-CM Diagnosis Code and Medication List.

- Infant's gestational age is less than 29 weeks, 0 days AND infant's chronological age is less than 12 months old as of November 1, 2015.
- Infant is 12 months old or younger (infant's first birthday is on or after November 1, 2015) with CLD of prematurity, defined as an infant with gestational age of less than 32 weeks, 0 days who required supplemental oxygen greater than 21% for at least the first 28 days after birth.
- Infant is 24 months old or younger (infant's second birthday is on or after November 1, 2015) with CLD of prematurity, defined as an infant with gestational age of less than 32 weeks, 0 days who required supplemental oxygen greater than 21% for at least the first 28 days after birth AND infant continued to require medical support (chronic systemic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the infant's second respiratory syncytial virus (RSV) season, which is November 1.
- Infant is 12 months old or younger (infant's first birthday is on or after November 1, 2015) with hemodynamically significant CHD WITH: (check one) (list applicable diagnosis codes \_\_\_\_\_)  
 \_\_\_\_\_ acyanotic heart disease AND is receiving medication to control congestive heart failure (CHF) such as diuretics, ACE inhibitors, beta-blockers or digoxin AND will require a cardiac surgical procedure.  
 \_\_\_\_\_ moderate to severe pulmonary hypertension.  
 \_\_\_\_\_ lesions that have been adequately corrected by surgery but continues to require medication for CHF such as diuretics, ACE inhibitors, beta-blockers or digoxin.  
 \_\_\_\_\_ cyanotic heart defect(s) AND decision for use of palivizumab was made with pediatric cardiologist consultation.
- Infant is younger than 2 years old on November 1, 2015 AND infant has undergone (or will undergo) cardiac transplantation during the RSV season (November 1, 2015 through March 31, 2016).
- Infant is 12 months old or younger (infant's first birthday is on or after November 1, 2015) AND infant has a congenital anatomic pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airway because of ineffective cough.
- Infant is younger than 24 months old on November 1, 2015 AND infant will be profoundly immunocompromised during RSV season (November 1, 2015 through March 31, 2016) due to \_\_\_\_\_.

**Is the patient currently in the hospital?** \_\_\_ Yes \_\_\_ No

**Has the patient been in the hospital since the start of the current RSV season (November 1, 2015)?** \_\_\_ Yes \_\_\_ No

**If Yes, was a dose of palivizumab administered while patient was hospitalized?** \_\_\_ Yes \_\_\_ No **If Yes, please provide date** \_\_\_\_\_.

Prescribing Physician Signature:\* \_\_\_\_\_ Date: \_\_\_\_\_

\*(Signature stamps and proxy signatures are not acceptable)

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