Fax this completed form to:
La Medicaid Rx P A Operations
ULM School of Pharmacy
1800 Bienville Drive
Monroe, LA 71201-3765
FAX 866-797-2329

State of Louisiana
Department of Health
Bureau of Health Services Financing
Palivizumab Clinical Pre-Authorization Form
For 2018- 2019 RSV Season

Palivizumab Form: Rx PA01P
Revised: 10/31/2018

VOICE PHONE 866-730-4357

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

Prescribing Provider Information	**Recipient Information**	
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 (e.g. hospital birth discharge notes, pediatric cardiologist consult notes and/or chart notes) for any submitted qualifying criteria or 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, 2018.

☐ Infant is 12 months old or younger (infant's first birthday is on or after November 1, 2018) 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, 2018) 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, 2018.

☐ Infant is 12 months old or younger (infant's first birthday is on or after November 1, 2018) 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, 2018 AND infant has undergone (or will undergo) cardiac transplantation during the RSV season (November 1, 2018 through March 31, 2019).

☐ Infant is 12 months old or younger (infant's first birthday is on or after November 1, 2018) 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, 2018 AND infant will be profoundly immunocompromised during RSV season (November 1, 2018 through March 31, 2019) 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, 2018)? _____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)*