John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PRIOR AUTHORIZATION REQUEST COVERSHEET

Please check the member's appropriate health plan listed below:

☐ **Aetna Better Health of Louisiana**
Phone: 1-855-242-0802 Fax: 1-844-699-2889
www.aetnabetterhealth.com/louisiana/providers/pharmacy

☐ **AmeriHealth Caritas Louisiana**
Phone: 1-800-684-5502 Fax: 1-855-452-9131
www.amerihealthcaritasla.com/pharmacy/index.aspx

☐ **Fee-for-Service (FFS) Louisiana Legacy Medicaid**
Phone: 1-866-730-4357 Fax: 1-866-797-2329
www.lamedicaid.com

☐ **Healthy Blue**
Phone: 1-844-521-6942 Fax: 1-844-864-7865
https://providers.healthybluela.com/la/pages/home.aspx

☐ **LA Healthcare Connections**
Retail Medication Requests:
Phone: 1-888-929-3790 Fax: 1-833-645-2733
Retail Electronic Prior Authorizations: https://www.covermymeds.com/main/prior-authorization-forms/
Physician Administered Medication Requests (Buy and Bill):
Phone: 1-866-595-8133 Fax: 1-866-925-3006
www.louisianahealthconnect.com/for-members/pharmacy-services/

☐ **United Healthcare**
Phone: 1-800-310-6826 Fax: 1-866-940-7328
https://www.uhcprovider.com/en/health-plans-by-state/louisiana-health-plans/la-comm-plan-home/la-cp-pharmacy.html
Electronic Prior Authorization: https://provider.linkhealth.com/#/

Louisiana Medicaid
Palivizumab Clinical Authorization Form

Palivizumab Form: Rx PA01P
Revised: 6/16/2022

Request utilizing this form 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 meets chronological age requirement as stated in criteria. (Criteria #1)
- ☐ Infant meets chronological age requirement as stated in criteria 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. (Criteria #2)
- ☐ Infant meets chronological age requirement as stated in criteria 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. (Criteria #2)
- ☐ Infant meets chronological age requirement as stated in criteria with hemodynamically significant CHD WITH: (check one) (list applicable diagnosis codes _____). (Criteria #3)
  - _____ acyanotic heart disease **AND** is receiving medication to control congestive heart failure (CHF) such as diuretics, ACE inhibitors, beta-blockers or digoxin 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 meets chronological age requirement as stated in criteria **AND** infant has undergone (or will undergo) cardiac transplantation. (Criteria #4)
- ☐ Infant meets chronological age requirement **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. (Criteria #5)
- ☐ Infant meets chronological age requirement **AND** infant will be profoundly immunocompromised during RSV season due to (list immunocompromising condition _____). (Criteria #6)

Is the patient currently in the hospital? ___Yes ___No

If Yes, was a dose of palivizumab administered while patient was hospitalized? ____Yes ____No If Yes, please provide date _____

Pharmacy Information (Optional) Pharmacy Name_____ Phone _____

Prescribing Physician Signature:* _____ Date:_____

(Signature stamps and proxy signatures are not acceptable)