

FAX this form to:  
(318) 812-2940

State of Louisiana  
Department of Health

Palivizumab Form: Rx PA02P  
Issue Date: 10/2012  
Revised Date: 10/01/2016

Or mail to:  
La. Medicaid Rx PA Operations  
ULM School of Pharmacy  
1800 Bienville Drive, Room 270  
Monroe, LA 71201-3765

Bureau of Health Services Financing  
Louisiana Medicaid Prescription Prior Authorization Program

Voice Phone:  
(866) 730-4357

**PALIVIZUMAB REQUEST FOR RECONSIDERATION**

Date of Request: \_\_\_\_\_  
Original PA #: \_\_\_\_\_

The prescriber may request reconsideration of a palivizumab clinical pre-authorization denial by completing the information on the form and faxing to the number above. As necessary, please provide copies of the recipient's medical records and/or lab results in addition to any supportive peer-reviewed literature to assist in evaluating therapy.

I. Provider Information		II. Recipient Information	
Provider Name (print):		Recipient Name (print):	
Provider Specialty:	Medicaid Provider ID:	Recipient Medicaid ID:	
Provider Phone:	Provider Fax:	Recipient Date of Birth:	
Office Contact Name:		Medication Allergies:	
III. Drug Information (One drug request per form.)			
Drug Name, Strength and Dosage Form:		Dosage Interval (sig):	Quantity per Month:
All diagnoses relevant to <u>this</u> request:			
Expected length of therapy:			
A. Has recipient previously received any doses of palivizumab? ___ Yes. If yes, please list dates that doses were given and dosage. (If yes, go to Item B) ___ No (Skip Item B. Indicate rationale for request in Section IV and submit form)			
Date(s) of previous palivizumab doses.		Dose of palivizumab given	
B. Has strength, dosage, or quantity required per month increased or decreased? ___ Yes ___ No (Indicate rationale for request in Section IV and submit form)			
IV. Rationale for Request / Pertinent Clinical Information (Required)			
Appropriate clinical information to support the request on the basis of medical necessity must be submitted.			
Provider Signature:			Date:

**INCOMPLETE FORMS WILL DELAY PROCESSING**

A final determination (approval or denial) through ULM Prior Authorization Unit will be made within 3 business days from the date of receipt of this request. This decision will be based on the clinical aspects of the case.

Check here to request telephone consultation