FAX this form to:
(318) 812-2940

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

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program

REQUEST FOR RECONSIDERATION

Palivizumab Form: Rx PA02
Issue Date: 10/2012

Voice Phone:
(866) 730-4357

Date of Request: _____

Original PA #:_____

The prescriber may request reconsideration of a drug prior 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 and Strength:	Dosage Form:	Dosage Interval (sig):	Qty per Day:
Diagnosis relevant to **this** request:			
Expected length of therapy:			

A. Is recipient currently treated on this medication?

☐ Yes. If yes, how long?_____ {If yes, go to Item B} ☐ No {Skip Items B & C. Go directly to Item D}

B. Is this request for continuation of a previous approval?

☐ Yes {If yes, go to Item C} ☐ No {Skip Item C. Go directly to Item D}

C. Has strength, dosage, or quantity required per day increased or decreased?

☐ Yes {If yes, go to Item D} ☐ No {Skip Item D. Indicate rationale for continuation in Section IV and submit form.}

D. Please indicate previous treatment and outcomes below:

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		

NOTE: Confirmation of use will be made from recipient history on file.

IV. Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)

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 48 business hours (8:00am – 4:30pm M-F) from receipt of this request. This decision will be based on the clinical aspects of the case.

☐ **Check here to request telephone consultation**