

FAX this form to:
 La Medicaid Rx PA Operations
 ULM College of Pharmacy
 FAX 866-797-2329
 PHONE 866-730-4357

State of Louisiana
Department of Health and Hospitals
 Bureau of Health Services Financing
Palivizumab Override Authorization Request

Form: Rx PA02
 Issue Date: 10/01/2012

Please type or print legibly. Incomplete forms will not be approved.

Date of Request		Number of Fax Pages	
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 (wks / days)	
FAX Number (include area code)	Recipient Current Weight _____ kg as of _____ (mm/dd/yy)		
Requested Drug Information			
Drug Name	Drug Strength	Quantity Prescribed per Month	
Diagnosis Code (ICD -9-CM) to Justify Palivizumab Use	Number of Doses Requested		

Please answer the following questions for your request to prescribe palivizumab for your patient:

- Is palivizumab administration during the RSV season, as defined by the LA Medicaid reimbursement criteria? YES NO
 If NO, explain use outside of criteria:
- Is recipient 24 months of age or younger on November 1st of current season? YES NO
 If NO, explain use outside of criteria:
- Is the diagnosis code to justify use contained in the LA Medicaid reimbursement criteria? YES NO
 If NO, explain use outside of criteria:
- Based upon the submitted diagnosis to justify use, is request within maximum number of doses set by LA Medicaid reimbursement criteria? YES NO
 If NO, explain use outside of criteria:

Prescribing Provider Signature: _____
(Handwritten signature of prescribing provider required. Signature stamps and proxy signatures are not acceptable.)

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