FAX this form to:
(318) 812-2940

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

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

PALIVIZUMAB REQUEST FOR RECONSIDERATION

Palivizumab Form: Rx PA02
Issue Date: 10/2012
Revised Date: 10/01/2014

Voice Phone:
(866) 730-4357

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 **this** 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**