FAX this form to:
(318) 812-2940

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

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

PALIVIZUMAB REQUEST FOR RECONSIDERATION

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

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**