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:

1. Is palivizumab administration during the RSV season, as defined by the LA Medicaid reimbursement criteria? ☐ YES ☐ NO
   If NO, explain use outside of criteria:

2. Is recipient 24 months of age or younger on November 1st of current season? ☐ YES ☐ NO
   If NO, explain use outside of criteria:

3. Is the diagnosis code to justify use contained in the LA Medicaid reimbursement criteria? ☐ YES ☐ NO
   If NO, explain use outside of criteria:

4. 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.)