Jeff Landry
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PRIOR AUTHORIZATION REQUEST COVERSHEET

Please check the member's appropriate health plan listed below:

☐	**Aetna Better Health of Louisiana**	Retail Pharmacy Requests **Phone**: 1-855-242-0802 **Fax**: 1-844-699-2889	Medical Benefit – Physician Administered Drugs **Phone**: 1-855-242-0802 **Fax**: 1-844-227-9205
☐	**AmeriHealth Caritas Louisiana**	Retail Pharmacy and Provider-Administered Drug Requests **Phone**: 1-800-684-5502 **Fax**: 1-855-452-9131	
☐	**Fee-for-Service (FFS) Louisiana Legacy Medicaid**	Retail Pharmacy Requests **Phone**: 1-866-730-4357 **Fax**: 1-866-797-2329	
☐	**Healthy Blue**	Retail Pharmacy Requests **Phone**: 1-844-521-6942 **Fax**: 1-855-592-0978	Medical Benefit – Physician Administered Drugs **Phone**: 1-844-521-6942 **Fax**: 1-844-487-9291
☐	**Humana**	Retail Pharmacy Requests **Phone**: 1-800-555-2546 **Fax**: 1-877-486-2621	Professionally Administered Drugs **Phone**: 1-866-461-7273 (M–F, 7am-10pm CT) **Fax**: 1-888-447-3430
☐	**LA Healthcare Connections**	Retail Pharmacy Requests **Phone**: 1-866-595-8133 **Fax**: 1-833-645-2733	Physician Administered Medication (Buy and Bill) **Phone**: 1-866-595-8133 **Fax**: 1-866-925-3006
☐	**UnitedHealthcare**	Retail Pharmacy Requests **Phone**:1-800-310-6826 **Fax**:1-866-940-7328	Medical Injectables **Phone**: 1-888-397-8129

Louisiana Medicaid
Palivizumab Clinical Authorization Form

Palivizumab Form: Rx PA01P
Effective Date: 10/01/2025

Requests utilizing this form must be faxed. Please type or print legibly. Incomplete forms will not be approved.
Requests submitted via electronic PA (ePA) must include all required information and supporting documentation. Date of Request_____

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 (weeks/days)
FAX Number (include area code)	Recipient Current Weight _____ kg as of _____ (mm/dd/yy)	
Drug and Strength Requested	Diagnosis Code(s) (ICD-10-CM) to Justify Palivizumab Use	
Office Contact Name	EPSDT Support Coordinator (Name / Address) (optional)	

Does the infant have additional insurance coverage (TPL)? ___ Yes ___ No If Yes, please contact TPL to determine coverage for this drug.

Is this request for palivizumab dosing in the child's second RSV season? ___Yes ___No

Does the child have a documented contraindication to nirsevimab that is not also a contraindication to palivizumab? [Supporting documentation must be provided] ___Yes ___No

Check the applicable high-risk condition that applies to this child. Attach supporting documentation (e.g. hospital birth discharge notes and/or chart notes) for any submitted qualifying criteria or ICD-10 diagnosis code(s).

☐ **The child is in their second RSV season and is at least 8 months of age but is less than 20 months of age on November 1.**

- ☐ Child with CLD of prematurity, defined as an infant with gestational age of less than 32 weeks, 0 days who required supplemental oxygen greater than 21% for at least the first 28 days after birth **AND** child continued to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) at any time during the 6-month period before the start of the infant's second respiratory syncytial virus (RSV) season, which is November 1.

- ☐ Child will be profoundly immunocompromised during RSV season (November 1 through March 31) due to _____ _____.

- ☐ Child has cystic fibrosis with **ONE** of the following:
  - ☐ Manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable), **OR**
  - ☐ Weight-for-length that is less than the 10th percentile.

- ☐ Child is American Indian or Alaska Native.

Has the infant received a dose of nirsevimab (Beyfortus™) for the current RSV season? _____Yes _____No

Pharmacy Information (Optional) Pharmacy Name_____ Phone _____

Prescribing Physician Signature:* _____ Date:_____

(Signature stamps and proxy signatures are not acceptable)