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
Phone: 1-855-242-0802 Fax: 1-844-699-2889
www.aetnabetterhealth.com/louisiana/providers/pharmacy

☐ AmeriHealth Caritas Louisiana
Phone: 1-800-684-5502 Fax: 1-855-452-9131
www.amerihealthcaritasla.com/pharmacy/index.aspx

☐ Fee-for-Service (FFS) Louisiana Legacy Medicaid
Phone: 1-866-730-4357 Fax: 1-866-797-2329
www.lamedicaid.com

☐ Healthy Blue
Phone: 1-844-521-6942 Fax: 1-844-864-7865
https://providers.healthybluela.com/la/pages/home.aspx

☐ LA Healthcare Connections
Phone: 1-888-929-3790 Fax: 1-866-399-0929
www.louisianahealthconnect.com/for-members/pharmacy-services/

☐ United Healthcare
Phone: 1-800-310-6826 Fax: 1-866-940-7328
Electronic Prior Authorization: https://provider.linkhealth.com/#/

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PLEASE CALL IF YOU HAVE ANY PROBLEMS RECEIVING THIS FAX OR IF PAGES ARE MISSING.
**Palivizumab Clinical Authorization Form**

For RSV Season*

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**Prescribing Provider Information**

<table>
<thead>
<tr>
<th>Name (Last, First)</th>
<th>LA Medicaid Prescribing Provider Number / NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LA Medicaid CCN or Recipient Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Call-Back Phone Number (include area code)</th>
<th>Date of Birth (mm/dd/yy)</th>
<th>Gestational Age (weeks/days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAX Number (include area code)</td>
<td>Recipient Current Weight</td>
<td>Diagnosis Code(s) (ICD-10-CM) to Justify Palivizumab Use</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office Contact Name</th>
<th>EPSDT Support Coordinator (Name / Address) (optional)</th>
</tr>
</thead>
</table>

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**Recipient Information**

<table>
<thead>
<tr>
<th>Name (Last, First)</th>
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**Does the patient have additional insurance coverage (TPL)?**

*Yes No* If Yes, please contact TPL to determine coverage for this drug.

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**Check the applicable age/condition.** For chronic lung disease (CLD) of prematurity/congenital heart disease (CHD), attach supporting documentation (e.g., hospital birth discharge notes, pediatric cardiologist consult notes and/or chart notes) for any submitted qualifying criteria or ICD-10 diagnosis code(s). Please refer to the Palivizumab Criteria ICD-10-CM Diagnosis Code and Medication List.

- Infant’s gestational age is less than 29 weeks, 0 days AND infant’s chronological age is less than 12 months old as of November 1.
- Infant is 12 months old or younger (infant’s first birthday is on or after November 1) 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.
- Infant is 24 months old or younger (infant’s second birthday is on or after November 1) 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 infant continued to require medical support (chronic systemic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the infant’s second respiratory syncytial virus (RSV) season, which is November 1.
- Infant is 12 months old or younger (infant’s first birthday is on or after November 1) with hemodynamically significant CHD WITH: (check one) (list applicable diagnosis codes ________________________________)
  - cyanotic heart disease AND is receiving medication to control congestive heart failure (CHF) such as diuretics, ACE inhibitors, beta-blockers or digoxin AND will require a cardiac surgical procedure.
  - moderate to severe pulmonary hypertension.
  - lesions that have been adequately corrected by surgery but continues to require medication for CHF such as diuretics, ACE inhibitors, beta-blockers or digoxin.
  - cyanotic heart defect(s) AND decision for use of palivizumab was made with pediatric cardiologist consultation.
- Infant is younger than 2 years old on November 1 AND infant has undergone (or will undergo) cardiac transplantation during the RSV season (November 1 through March 31).
- Infant is 12 months old or younger (infant’s first birthday is on or after November 1) AND infant has a congenital anatomic pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airway because of ineffective cough.
- Infant is younger than 24 months old on November 1 AND infant will be profoundly immunocompromised during RSV season (November 1 through March 31) due to ____________________.

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**Is the patient currently in the hospital?**

*Yes No*

**Has the patient been in the hospital since the start of the current RSV season (November 1)?**

*Yes No* If Yes, please provide date __________

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**Pharmacy Information (Optional)**

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Phone</th>
</tr>
</thead>
</table>

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**Prescribing Physician Signature:**

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