



State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PRIOR AUTHORIZATION REQUEST COVERSHEET

<input type="checkbox"/> Aetna Better Health of Louisiana	Retail Pharmacy Requests Phone: 1-855-242-0802 Fax: 1-844-699-2889 www.aetnabetterhealth.com/louisiana/providers/pharmacy	Medical Benefit - Physician Administered Drugs Phone: 1-855-242-0802 Fax: 1-844-227-9205 TTY: 1-855-242-0802, 711
<input type="checkbox"/> AmeriHealth Caritas Louisiana	Retail Pharmacy and Provider-Administered Drug Requests Phone: 1-800-684-5502 Fax: 1-855-452-9131 https://www.amerihealthcaritasla.com/pharmacy/priorauth.aspx	
<input type="checkbox"/> Fee-for-Service (FFS) Louisiana Legacy Medicaid	Retail Pharmacy Requests Phone: 1-866-730-4357 Fax: 1-866-797-2329 www.lamedicaid.com	
<input type="checkbox"/> Healthy Blue	Retail Pharmacy Requests Phone: 1-844-521-6942 Fax: 1-844-864-7865 https://providers.healthyblue.com/la/pages/home.aspx	Medical Injectables: Phone: 1-844-521-6942 (M-F 7a-7p; Sat 9-1p CT) Fax 1-844-487-9291 CenterX®: Submit through EPIC EMR
<input type="checkbox"/> Humana	Retail Pharmacy Requests Phone: 1-866-730-4357 Fax: 1-866-797-2329 www.lamedicaid.com	Professionally Administered Drugs Availity.com (registration required) Phone: 1-866-461-7273 (M-F 7a-10p CT) Fax 1-888-447-3430 (request form at Humana.com/medPA)
<input type="checkbox"/> LA Healthcare Connections	Retail Pharmacy Requests Phone: 1-888-929-3790 Fax: 1-866-399-0929 www.louisianahealthconnect.com/for-members/pharmacy-services/	Physician Administered Medication Requests (Buy and Bill) Phone: 1-866-595-8133 Fax: 1-866-925-3006
<input type="checkbox"/> United Healthcare	Retail Pharmacy Requests Phone: 1-800-310-6826 Fax: 1-866-940-7328 https://www.uhcprovider.com/en/health-plans-by-state/louisiana-health-plans/la-comm-plan-home/la-cp-pharmacy.html Electronic Prior Authorization: https://provider.linkhealth.com/#/	Medical Benefit Phone: 1-888-397-8129 Fax: 1-877-271-6290 www.UHCprovider.com

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Louisiana Medicaid
Palivizumab Clinical Authorization Form

Palivizumab Form: Rx PA01P
Revised: 8/22/2023

Requests utilizing this form must be faxed. Please type or print legibly. Incomplete forms will not be approved.

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

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 _____).
 - _____ acyanotic 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 _____.

Is the patient currently in the hospital? ___ Yes ___ No

If Yes, was a dose of palivizumab administered while patient was hospitalized? ___ Yes ___ No **If Yes, please provide date** _____

Has the patient 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)

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