Jeff Landry
GOVERNOR

Michael Harrington, MBA, MA
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:

Retail Pharmacy Requests

☐ **Prime Therapeutics State Government Solutions LLC**
For Aetna Better Health of Louisiana, AmeriHealth Caritas Louisiana, Healthy Blue, Humana, LA Healthcare Connections, United Healthcare
Phone: 1-800-424-1664 / Fax: 1-800-424-7402

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

Requests for Medications Through Medical Benefit

☐ **Aetna Better Health of Louisiana** – Medical Benefit – Physician Administered Drugs
Phone: 1-855-242-0802 / Fax: 1-844-227-9205 / TTY: 1-855-242-0802, 711

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

☐ **Healthy Blue** – Medical Injectables
Phone: 1-844-521-6942 (M-F 7a-7p; Sat 9a-1p CT) / Fax: 1-844-487-9291
CenterX®: Submit through EPIC EMR

☐ **Humana** – 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)

☐ **LA Healthcare Connections** – Physician Administered Medication (Buy and Bill)
Phone: 1-866-595-8133 / Fax: 1-866-925-3006

☐ **United Healthcare** – Medical Benefit
Phone: 1-888-397-8129 / Fax: 1-877-271-6290 / www.UHCprovider.com

Print Reset

Prime THERAPEUTICS

Louisiana Medicaid

Palivizumab Clinical Authorization Form

Fax this form to 1-800-424-7402

Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). Incomplete forms will not be approved. Information contained in this form is Protected Health Information under HIPAA.

SECTION 1: SUBMISSION

Submitted to: _____

Receiver Phone: _____ Receiver Fax: _____ Date: _____

SECTION 2: PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____ Middle Initial: _____

Prescriber NPI: _____ Plan Provider #: _____ Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

Office Contact Name: _____ Contact Phone: _____

SECTION 3: PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____ Middle Initial: _____

Date of Birth: _____ Gestational Age: _____ Weeks _____ Days

Current Weight: _____ kg As of Date: _____

Patient Phone: _____ Sex: ☐ Male ☐ Female ☐ Other ☐ Unknown

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Plan Name (if different from Section 1): _____

Member #: _____ Medicaid #: _____ Plan Provider ID: _____

CCN #: _____

EPSDT Support Coordinator contact information (optional):

EPSDT Support Coordinator First Name: _____

EPSDT Support Coordinator Last Name: _____

EPSDT Support Coordinator Phone: _____

Patient's Name: _____

SECTION 4: PRESCRIPTION DRUG INFORMATION

Drug Name: _____ Drug Strength: _____

Dosage Form: _____ Route of Admin.: _____

Quantity: _____ Day Supply: _____ Dosage Interval: _____

Directions for Use: _____

SECTION 5: CRITERIA

1. Diagnosis Code(s) ICD-10-CM to justify palivizumab: _____
2. Does the patient have additional insurance coverage (TPL)?
   ☐ Yes ☐ No

   If Yes, contact TPL to determine coverage for this drug.
3. 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** the following: (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.

Patient's Name: _____

SECTION 5: CRITERIA *(CONTINUED)*

☐ 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 the following:

List immunocompromising condition: _____

4. Is the patient currently in the hospital?
   ☐ Yes ☐ No
5. **If Yes,** was a dose of palivizumab administered while patient was hospitalized?
   ☐ Yes ☐ No

   If Yes, please provide date: _____
6. Has the infant received a dose of nirsevimab (Beyfortus™) for the current RSV season?
   ☐ Yes ☐ No
7. Is the infant younger than 7 months old **and** received protection from severe LRTD RSV via maternal vaccination with Abrysvo™?
   ☐ Yes ☐ No

SECTION 9: PHARMACY INFORMATION (OPTIONAL)

Name of Dispensing Pharmacy: _____

Pharmacy NPI: _____ Pharmacy Phone: _____

Pharmacy Street Address: _____

City: _____ State: _____ Zip: _____

☐ Attachments

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Prescribing Physician Signature*: _____

*(Signature stamps and proxy signatures are not acceptable.)

Date of Prescribing Physician Signature: _____

Mail requests to:

Prime Therapeutics State Government Solutions LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 1-800-424-1664

Patient's Name: _____

Fax this form to 1-800-424-7402