John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
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

☐ **Magellan Medicaid Administration, 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: 855-242-0802 / Fax: 844-227-9205 / TTY: 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
1-844-521-6942 (M–F 7 a.m.–7 p.m., Sat. 9 a.m.–1 p.m. CT) / Fax: 844-487-9291
CenterX®: Submit through EPIC EMR

☐ **Humana** – Professionally Administered Drugs
Availity.com (registration required)
Phone: 1-866-461-7273 (M–F 7 a.m.–10 p.m. 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: 877-271-6290 / www.UHCprovider.com

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Magellan Medicaid Administration

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: ____________________

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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 meets chronological age requirement as stated in criteria. (Criteria #1)

   ☐ Infant meets chronological age requirement as stated in criteria 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. (Criteria #2)

   ☐ Infant meets chronological age requirement as stated in criteria 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. (Criteria #2)

   ☐ Infant meets chronological age requirement as stated in criteria with **hemodynamically significant** CHD **with** the following: (Check one)

   List applicable diagnosis codes: ______________________________. (Criteria #3)

   - ☐ Acyanotic heart disease **and** is receiving medication to control congestive heart failure (CHF) such as diuretics, ACE inhibitors, beta-blockers or digoxin **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 meets chronological age requirement as stated in criteria **and** infant has undergone (or will undergo) cardiac transplantation. (Criteria #4)
- ☐ Infant meets chronological age requirement **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. (Criteria #5)
- ☐ Infant meets chronological age requirement **and** infant will be **profoundly** immunocompromised during RSV season due to the following:

  List immunocompromising condition: ______________________________ (Criteria #6)

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:

Magellan Medicaid Administration, 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

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