

**NEBRASKA MEDICAID  
RESPIRATORY SYNCYTIAL VIRUS (RSV)  
PROPHYLAXIS PRIOR AUTHORIZATION FORM**

Client Name: _____			Client Medicaid ID: _____			Client DOB: _____		
Gestational Age: weeks _____		days _____		Age at start of RSV season: _____		Wt: _____ kg.		
Physician (print): _____				NPI _____		Medicaid ID _____		
Physician Address: _____				Fax: _____		Phone: _____		

This authorization form applies to fee-for-service clients.

- Documentation to support this clinical information **MUST** be included with this prior authorization
- Chronological age is at the start of the RSV season
- Check all criteria below that applies.

- Gestational Age < 29 weeks and 0 days gestation and is younger than 12 months at the start of the RSV season.
- Gestational Age < 32 weeks and 0 days gestation and is ≤ 12 months of age at the start of the RSV season with Chronic Lung Disease (CLD) and a requirement for >21% oxygen for at least the first 28 days after birth OR;
- Child in second year of life who satisfies the definition of CLD above AND continues to require medical support (chronic corticosteroid or diuretic therapy, or supplemental oxygen) during the 6-month period before the second RSV season.
- ≤ 12 months of age with hemodynamically congenital heart disease (CHD), acyanotic heart disease requiring medication and will require cardiac surgical procedures OR with moderate to severe pulmonary hypertension.
- < 24 months of age who has undergone cardiac transplantation during the RSV season.
- ≤ 12 months of age with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways.
- ≤ 24 months of age who is profoundly immunocompromised during the RSV season.

Has the child received any doses of RSV prophylaxis this season?  Yes  No If yes, number of doses given \_\_\_\_\_

Ordering physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Submit this form to Nebraska Division of Medicaid and Long-Term Care Pharmacy Program Specialist with cover sheet and supporting documentation by paper Fax to (402) 471-9092 or eFax to (402) 742-2348.

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**DO NOT WRITE BELOW THIS LINE - FOR MEDICAID USE ONLY**

- Approved for RSV prophylaxis. Number of doses approved: \_\_\_\_\_ months for dates of \_\_\_\_\_ through \_\_\_\_\_.
- Denied RSV prophylaxis. Rationale \_\_\_\_\_

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Department Signature \_\_\_\_\_ Date \_\_\_\_\_