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.

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 ____________________________________________________

Department Signature __________________________ Date ______________

7/29/2019