

**2014/2015 NEBRASKA MEDICAID RESPIRATORY SYNCYTIAL VIRUS
PROPHYLAXIS PRIOR AUTHORIZATION FORM**

Client Name: _____ Medicaid ID: _____

Physician (print): _____ Client DOB: _____

Gestational Age: weeks ____ days ____ Age at start of RSV season: _____ Wt: ____ kg.

- Documentation to support this clinical information **MUST** be included with this prior authorization
- Chronological age is at the start of the RSV season
- Mark which criteria applies to meet RSV needed criteria below

- 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 \leq 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.
- \leq 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.
- \leq 12 months of age with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways.
- \leq 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, ____ doses given

Physician Signature: _____ Date: _____

Physician Address: _____

Fax: _____ Phone: _____

Submit this form to Nebraska Division of Medicaid and Long-Term Care Program Specialist with cover sheet indicating RSV Prophylaxis by paper Fax to (402) 471-9092 or eFax to (402) 742-1104.

DO NOT WRITE BELOW THIS LINE - FOR MEDICAID USE ONLY

- Approved for RSV prophylaxis for 2014/2015 season. Number of doses approved: _____ months for dates of _____ through _____.
- Denied RSV prophylaxis for 2014/2015 season. Rationale _____

Program Specialist _____

Date _____