



**NEBRASKA MEDICAID RESPIRATORY SYNCYTIAL VIRUS  
2016-2017 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 ≤ 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, \_\_\_\_ 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) 742-2348.

**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 \_\_\_\_\_