NEBRASKA MEDICAID RESPIRATORY SYNCYTIAL VIRUS
2018-2019 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 Envolve Pharmacy Solutions/Nebraska Total Care to fax 866-399-0929 or call 844-330-7852