

**Louisiana Medicaid
Quantity Limit
Selected Anti-Infective, Anti-Fungal and Corticosteroid Medications**

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request authorization to override the quantity limits listed in the table below.

Medication	Dosage Form	Quantity Limit
Ciclopirox Olamine 0.77%	Suspension	60ml/30 days
Ciprofloxacin HCl 0.2%	Otic Solution	2 packs of 14 singles/30 days
Clobetasol Propionate 0.05%	Cream	100gm/30 days
Clobetasol Propionate 0.05%	Ointment	120gm/30 days
Clobetasol Propionate 0.05%	Solution	100ml/30 days
Doxycycline Hyclate / Monohydrate	Capsule	60 caps of any strength/30 days
Econazole Nitrate 1%	Cream	85gm/30 days
Gentamicin Sulfate 0.3%	Ophthalmic Ointment	3.5gm/30 days
Gentamicin Sulfate 0.3%	Ophthalmic Solution	5ml/30 days
Gentamicin Sulfate 0.1%	Cream	30gm/30 days
Gentamicin Sulfate 0.1%	Ointment	30gm/30 days
Itraconazole 100mg	Capsule	120 caps/30 days
Itraconazole 100mg	Capsule Pulsepak	1 pack (28 caps) / 28 days
Itraconazole 65mg	Capsule	120 caps/30 days
Ketoconazole 2%	Shampoo	120ml/30 days
Ketoconazole 2%	Cream	60gm/30 days
Mupirocin 2%	Cream	30gm/30 days
Mupirocin 2%	Ointment	22gm/30 days
Nystatin 100,000 units/gm	Cream	60gm/30 days
Nystatin 100,000 units/gm	External Powder	60gm bottle; 2 bottles/30 days
Nystatin 100,000 units/gm	Ointment	60gm/30 days

Approval Criteria

- The authorization request form is completed in full including, but not limited to, the quantity prescribed, route of administration and the directions for use; **AND**
- The prescribed dose, route of administration and/or quantity of the requested medication:
 - is consistent with the manufacturer's prescribing information; **OR**
 - falls within dosing guidelines found in the compendia of current literature [such as American Hospital Formulary Service Drug Information, Thomson Micromedex DrugDex, United States Pharmacopeia – Drug Information (USP-DI)], which shows clinical value in the quantity prescribed and the directions for use [Source(s) are **stated on the request**]; **AND**
- By submitting the authorization request, the prescriber attests to the following:

- o The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
- o The requested dosage cannot be achieved using the plan-accepted quantity limit of a different dose or formulation of the same medication; **AND**
- o All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
- o The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Duration of approval: Up to 6 months

An appropriate duration of authorization approval will be determined based upon patient-specific factors and the condition being treated.

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