**FAX this form to:**
(318) 812-2940

**Or mail to:**
La. Medicaid Rx PA Operations
ULM College of Pharmacy
1800 Bienville Drive, Rm 270
Monroe, LA 71201-3765

**State of Louisiana**
**Department of Health**
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program

Form: Rx PA02
Issue Date: 10/15/12
Revised Date: 6/6/19

**Voice Phone:**
(866) 730-4357

**Date of Request:** _____

**Original PA #:** _____

# REQUEST FOR RECONSIDERATION

The prescriber may request reconsideration of a drug prior authorization denial by completing the information on the form and faxing to the number above. As necessary, please provide copies of the recipient's medical records and/or lab results in addition to any supportive peer-reviewed literature to assist in evaluating therapy.

| **I. Provider Information** | | **II. Recipient Information** |
|---|---|---|
| Provider Name (print): | | Recipient Name (print): |
| Provider Specialty: | Medicaid Provider ID: | Recipient Medicaid ID: |
| Provider Phone: | Provider Fax: | Recipient Date of Birth: |
| Office Contact Name: | EPSDT Support Coordinator (Name/Address): *(optional)* | Medication Allergies: |

**III. Drug Information (One drug request per form.)**

| Drug Name and Strength: | Dosage Form: | Dosage Interval (sig): | Qty per Day: |
|---|---|---|---|

Diagnosis relevant to **this** request:

Expected length of therapy:

**A.** Is recipient currently treated on this medication?
☐ Yes. If yes, how long?_____{If yes, go to Item B} ☐ No {Skip Items B & C. Go directly to Item D}

**B.** Is this request for continuation of a previous approval?
☐ Yes {If yes, go to Item C} ☐ No {Skip Item C. Go directly to Item D}

**C.** Has strength, dosage, or quantity required per day increased or decreased?
☐ Yes {If yes, go to Item D} ☐ No {Skip Item D. Indicate rationale for continuation in Section IV and submit form.}

**D.** Please indicate previous treatment and outcomes below:

| Drug Name (include strength and dosage) | Dates of Therapy | Reason for Discontinuation |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |

NOTE: Confirmation of use will be made from recipient history on file; prior use of preferred drugs is a part of the exception criteria.

**IV. Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)**

| Appropriate clinical information to support the request on the basis of medical necessity must be submitted. | **Provider Signature:** | **Date:** |
|---|---|---|

**INCOMPLETE FORMS WILL DELAY PROCESSING**

**A final determination (approval or denial) through ULM Prior Authorization Unit will be made within 3 business days from date of receipt of this request. This decision will be based on the clinical aspects of the case.**

☐ **Check here to request telephone consultation**