



# State of Louisiana

Louisiana Department of Health  
Bureau of Health Services Financing

## PRIOR AUTHORIZATION REQUEST COVERSHEET

Please check the member's appropriate health plan listed below:

### Retail Pharmacy Requests

- Magellan Medicaid Administration**  
*For Aetna Better Health of Louisiana, AmeriHealth Caritas Louisiana, Healthy Blue, Humana, LA Healthcare Connections, United Healthcare*  
Phone: 1-800-424-1664 / Fax: 1-800-424-7402
- Fee-for-Service (FFS) Louisiana Legacy Medicaid**  
Phone: 1-866-730-4357 / Fax: 1-866-797-2329 / [www.lamedicaid.com](http://www.lamedicaid.com)

### Requests for Medications Through Medical Benefit

- Aetna Better Health of Louisiana** – Medical Benefit – Physician Administered Drugs  
Phone: 1-855-242-0802 / Fax: 1-844-227-9205 / TTY: 1-855-242-0802, 711
- AmeriHealth Caritas Louisiana**  
Phone: 1-800-684-5502 / Fax: 1-855-452-9131 [www.amerihealthcaritasla.com/pharmacy/priorauth.aspx](http://www.amerihealthcaritasla.com/pharmacy/priorauth.aspx)
- Healthy Blue** – Medical Injectables  
Phone: 1-844-521-6942 (M-F 7a-7p; Sat 9a-1p CT) / Fax: 1-844-487-9291  
CenterX®: Submit through EPIC EMR
- Humana** – Professionally Administered Drugs  
[Availity.com](http://Availity.com) (registration required)  
Phone: 1-866-461-7273 (M-F 7a-10p CT) / Fax: 1-888-447-3430 (request form at [Humana.com/medPA](http://Humana.com/medPA))
- LA Healthcare Connections** – Physician Administered Medication (Buy and Bill)  
Phone: 1-866-595-8133 / Fax: 1-866-925-3006
- United Healthcare** – Medical Benefit  
Phone: 1-888-397-8129 / Fax: 1-877-271-6290 / [www.UHCprovider.com](http://www.UHCprovider.com)

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**LOUISIANA UNIFORM PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM**

**SECTION I — SUBMISSION**

Submitted to:	Phone:	Fax:	Date:
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**SECTION II — PRESCRIBER INFORMATION**

Last Name, First Name MI:		NPI# or Plan Provider #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

**SECTION III — PATIENT INFORMATION**

Last Name, First Name MI:		DOB:	Phone:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
				<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
Address:		City:	State:	ZIP Code:	
Plan Name (if different from Section I):	Member or Medicaid ID #:	Plan Provider ID:			
Patient is currently a hospital inpatient getting ready for discharge? ___ Yes ___ No Date of Discharge: _____					
Patient is being discharged from a psychiatric facility? ___ Yes ___ No Date of Discharge: _____					
Patient is being discharged from a residential substance use facility? ___ Yes ___ No Date of Discharge: _____					
Patient is a long-term care resident? ___ Yes ___ No If yes, name and phone number: _____					
EPSDT Support Coordinator contact information, if applicable: _____					

**SECTION IV — PRESCRIPTION DRUG INFORMATION**

Requested Drug Name:						
Strength:	Dosage Form:	Route of Admin:	Quantity:	Days' Supply:	Dosage Interval/Directions for Use:	Expected Therapy Duration/Start Date:
To the best of your knowledge this medication is: ___ New therapy/Initial request ___ Continuation of therapy/Reauthorization request						
<b>For Provider Administered Drugs only:</b>						
HCPCS/CPT-4 Code: _____ NDC#: _____ Dose Per Administration: _____						
Other Codes: _____						
Will patient receive the drug in the physician's office? ___ Yes ___ No – If no, list name and NPI of servicing provider/facility: _____						

**SECTION V — PATIENT CLINICAL INFORMATION**

Primary diagnosis relevant to this request:		ICD-10 Diagnosis Code:	Date Diagnosed:
Secondary diagnosis relevant to this request:		ICD-10 Diagnosis Code:	Date Diagnosed:
For pain-related diagnoses, pain is: ___ Acute ___ Chronic			
For postoperative pain-related diagnoses: Date of Surgery _____			
Pertinent laboratory values and dates (attach or list below):			
Date	Name of Test	Value	

**SECTION VI - This Section For Opioid Medications Only**

Does the quantity requested exceed the max quantity limit allowed? \_\_\_Yes \_\_\_No (If yes, provide justification below.)

Cumulative daily MME \_\_\_\_\_

Does cumulative daily MME exceed the daily max MME allowed? \_\_\_Yes \_\_\_No (If yes, provide justification below.)

SHORT AND LONG-ACTING OPIOIDS	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
			B. The patient has been <b>screened for substance abuse / opioid dependence</b> . <i>(Not required for recipients in long-term care facility.)</i>
			C. The <b>PMP</b> will be accessed <b>each</b> time a controlled prescription is written for this patient.
			D. A <b>treatment plan</b> which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			E. <b>Criteria</b> for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			F. <b>Benefits and potential harms</b> of opioid use have been discussed with this patient.
			G. An <b>Opioid Treatment Agreement</b> signed by both the patient and prescriber is on file. <i>(Not required for recipients in long-term care facility.)</i>
LONG-ACTING OPIOIDS			H. The patient requires continuous <b>around the clock</b> analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			I. Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in pharmacologic/non-pharmacologic treatment section below.
			J. Medication has <b>not</b> been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			K. Medication has <b>not</b> been prescribed for use as an as-needed (PRN) analgesic.
			L. Prescribing information for requested product has been <b>thoroughly reviewed</b> by prescriber.

IF NO FOR ANY OF THE ABOVE (A-L), PLEASE EXPLAIN:

**SECTION VII - Pharmacologic & non-pharmacologic treatment(s) used for this diagnosis (both previous & current):**

Drug name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason

Drug Allergies: \_\_\_\_\_ Height (if applicable): \_\_\_\_\_ Weight (if applicable): \_\_\_\_\_

Is there clinical evidence or patient history that suggests the use of the plan's pre-requisite medication(s), e.g. step medications, will be ineffective or cause an adverse reaction to the patient? \_\_\_Yes \_\_\_No (If yes, please explain in Section VIII below.)

**SECTION VIII — JUSTIFICATION (SEE INSTRUCTIONS)**

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Signature of Prescriber: \_\_\_\_\_

Date: \_\_\_\_\_