PRIOR AUTHORIZATION REQUEST COVERSHEET

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

☐ Aetna Better Health of Louisiana
  Phone: 1-855-242-0802  Fax: 1-844-699-2889
  www.aetnabetterhealth.com/louisiana/providers/pharmacy

☐ AmeriHealth Caritas Louisiana
  Phone: 1-800-684-5502  Fax: 1-855-452-9131
  www.amerihealthcaritasla.com/pharmacy/index.aspx

☐ Fee-for-Service (FFS) Louisiana Legacy Medicaid
  Phone: 1-866-730-4357  Fax: 1-866-797-2329
  www.lamedicaid.com

☐ Healthy Blue
  Phone: 1-844-521-6942  Fax: 1-844-864-7865
  https://providers.healthybluela.com/la/pages/home.aspx

☐ LA Healthcare Connections
  Phone: 1-888-929-3790  Fax: 1-866-399-0929
  www.louisianahealthconnect.com/for-members/pharmacy-services/

☐ United Healthcare
  Phone: 1-800-310-6826  Fax: 1-866-940-7328
  Electronic Prior Authorization: https://provider.linkhealth.com/#/

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PLEASE CALL IF YOU HAVE ANY PROBLEMS RECEIVING THIS FAX OR IF PAGES ARE MISSING.

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana
Louisiana Department of Health
Bureau of Health Services Financing

Bienville Building  •  628 N. Fourth St  •  P.O. Box 91030  •  Baton Rouge, Louisiana 70821-9030
Pharmacy Helpdesk Phone: (800) 437-9101
An Equal Opportunity Employer
LOUISIANA UNIFORM PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

SECTION I — SUBMISSION
Submitted to: ___________________________ Phone: ___________________________ Fax: ___________________________ Date: ___________________________

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: ___________________________
[ ] Male [ ] Female [ ] Other [ ] 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:

<table>
<thead>
<tr>
<th>Strength:</th>
<th>Dosage Form:</th>
<th>Route of Admin:</th>
<th>Quantity:</th>
<th>Days' Supply:</th>
<th>Dosage Interval/Directions for Use:</th>
<th>Expected Therapy Duration/Start Date:</th>
</tr>
</thead>
</table>

To the best of your knowledge this medication is: [ ] New therapy/Initial request  [ ] Continuation of therapy/Reauthorization request

For Provider Administered Drugs only:

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):

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
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</tr>
</tbody>
</table>
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.)

<table>
<thead>
<tr>
<th>YES (True)</th>
<th>NO (False)</th>
<th>THE PRESCRIBER ATTESTS TO THE FOLLOWING:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. A complete assessment for pain and function was performed for this patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. The patient has been screened for substance abuse / opioid dependence. (Not required for recipients in long-term care facility.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. The PMP will be accessed each time a controlled prescription is written for this patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. A treatment plan which includes current and previous goals of therapy for both pain and function has been developed for this patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Criteria for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Benefits and potential harms of opioid use have been discussed with this patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. An Opioid Treatment Agreement signed by both the patient and prescriber is on file. (Not required for recipients in long-term care facility.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. The patient requires continuous around the clock analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Medication has not been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Medication has not been prescribed for use as an as-needed (PRN) analgesic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L. Prescribing information for requested product has been thoroughly reviewed by prescriber.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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):

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Strength</th>
<th>Frequency</th>
<th>Dates Started and Stopped or Approximate Duration</th>
<th>Describe Response, Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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: __________________________

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