

# Healthy Louisiana Pharmacy Prior Authorization Form

**Aetna Better Health of Louisiana**  
 Phone: 1-855-242-0802 Fax: 1-844-699-2889  
[www.aetnabetterhealth.com/louisiana/providers/pharmacy](http://www.aetnabetterhealth.com/louisiana/providers/pharmacy)

**Healthy Blue**  
 Phone: 1-844-521-6942 Fax: 1-844-864-7865  
[providers.healthyblue.com](http://providers.healthyblue.com)

**AmeriHealth Caritas Louisiana**  
 Phone: 1-800-684-5502 Fax: 1-855-452-9131  
[www.amerihhealthcaritasla.com/pharmacy/index.aspx](http://www.amerihhealthcaritasla.com/pharmacy/index.aspx)

**LA Healthcare Connections**  
 Phone: 1-888-929-3790 Fax: 1-866-399-0929  
[www.louisianahealthconnect.com/for-members/pharmacy-services/](http://www.louisianahealthconnect.com/for-members/pharmacy-services/)

**Fee-for-Service (FFS) Louisiana Legacy Medicaid**  
 Phone: 1-866-730-4357 Fax: 1-866-797-2329  
[www.lamedicaid.com](http://www.lamedicaid.com)

**United Healthcare**  
 Phone: 1-800-310-6826 Fax: 1-866-940-7328  
[www.uhcommunityplan.com/health-professionals/la/pharmacy.html](http://www.uhcommunityplan.com/health-professionals/la/pharmacy.html)

## MEMBER INFORMATION

Patient Name: (Last Name)		(First Name)	(MI)
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:
Address: (Street)		(City)	(State) (Zip Code)
Phone Number:	Policy ID Number:	Member is Currently Inpatient: <input type="checkbox"/> Yes <input type="checkbox"/> No	

## PRESCRIBER INFORMATION

Practice Name:	Specialty:	NPI Number (2):	
Physician Name:	NPI Number (1):	DEA/License Number:	
Address: (Street)		(City)	(State) (Zip Code)
Phone Number:	Fax Number:		

## MEDICATION INFORMATION Expedited Request: Yes No (If yes, explain below)

Drug Name:		Quantity:
Strength:	Directions:	
Dispense as written: <input type="checkbox"/> Yes <input type="checkbox"/> No	Substitution Permitted: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Refills:
Currently on this medication: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other medications tried to treat this condition:	Dates:
List other current medications: ( <input type="checkbox"/> See attached list)		
Reasons for discontinuation of tried therapies:		
Diagnosis/Indication:		ICD Diagnosis Code:
Rationale and/or other information relevant to the review of this request (explain reason for expedited request if applicable): ( <input type="checkbox"/> Included lab results)		
Drug Allergies:	EPSDT Support Coordinator (optional): (Name/Address)	

## PHARMACY INFORMATION

Pharmacy Name:	Phone Number:	Fax Number:
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Physician Signature: \_\_\_\_\_

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

*Pharmacies are allowed to dispense a 72 hour emergency supply while authorization is pending.*