



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

- Prime Therapeutics State Government Solutions LLC**
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

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
- 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 (registration required)
Phone: 1-866-461-7273 (M-F 7a-10p CT) / Fax: 1-888-447-3430 (request form at 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

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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: | <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? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Discharge: _____ | | | | | |
| Patient is being discharged from a psychiatric facility? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Discharge: _____ | | | | | |
| Patient is being discharged from a residential substance use facility? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Discharge: _____ | | | | | |
| Patient is a long-term care resident? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> New therapy/Initial request <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Acute <input type="checkbox"/> 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 screened for substance abuse / opioid dependence . (Not required for recipients in long-term care facility.) |
| | | | C. The PMP will be accessed each time a controlled prescription is written for this patient. |
| | | | D. A treatment plan which includes current and previous goals of therapy for both pain and function has been developed for this patient. |
| | | | E. Criteria for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient. |
| | | | F. Benefits and potential harms of opioid use have been discussed with this patient. |
| | | | G. An Opioid Treatment Agreement signed by both the patient and prescriber is on file. (Not required for recipients in long-term care facility.) |
| LONG-ACTING OPIOIDS | | | H. The patient requires continuous around the clock 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 not 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 not been prescribed for use as an as-needed (PRN) analgesic. |
| | | | L. Prescribing information for requested product has been thoroughly reviewed 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: _____