



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:

☐ Aetna Better Health of Louisiana	Retail Pharmacy Requests Phone: 1-855-242-0802 Fax: 1-844-699-2889	Medical Benefit – Physician Administered Drugs Phone: 1-855-242-0802 Fax: 1-844-227-9205
☐ AmeriHealth Caritas Louisiana	Retail Pharmacy and Provider-Administered Drug Requests Phone: 1-800-684-5502 Fax: 1-855-452-9131	
☐ Fee-for-Service (FFS) Louisiana Legacy Medicaid	Retail Pharmacy Requests Phone: 1-866-730-4357 Fax: 1-866-797-2329	
☐ Healthy Blue	Retail Pharmacy Requests Phone: 1-844-521-6942 Fax: 1-855-592-0978	Medical Benefit – Physician Administered Drugs Phone: 1-844-521-6942 Fax: 1-844-487-9291
☐ Humana	Retail Pharmacy Requests Phone: 1-800-555-2546 Fax: 1-877-486-2621	Professionally Administered Drugs Phone: 1-866-461-7273 (M–F, 7am-10pm CT) Fax: 1-888-447-3430
☐ LA Healthcare Connections	Retail Pharmacy Requests Phone: 1-866-595-8133 Fax: 1-833-645-2733	Physician Administered Medication (Buy and Bill) Phone: 1-866-595-8133 Fax: 1-866-925-3006
☐ UnitedHealthcare	Retail Pharmacy Requests Phone: 1-800-310-6826 Fax: 1-866-940-7328	Medical Injectables Phone: 1-888-397-8129

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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:	☐ 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:						
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						
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):			
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:
			A. A complete assessment for pain and function was performed for this patient.
			B. The patient has been screened for substance abuse / opioid dependence . <i>(Not required for recipients in long-term care facility.)</i>
			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. <i>(Not required for recipients in long-term care facility.)</i>
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: _____