**John Bel Edwards**
GOVERNOR

**Rebekah E. Gee MD, MPH**
SECRETARY

# State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

**MEMORANDUM**

**DATE:** December 14, 2018

**TO:** All Louisiana Medicaid Prescribing Providers and Pharmacists

**FROM:** Jen Steele, Medicaid Director

**SUBJECT:** Louisiana Medicaid Fee for Service (FFS) and Managed Care Organizations (MCOs) Pharmacy Implementation of Louisiana Uniform Prescription Drug Prior Authorization (PA) Form

Effective January 1, 2019, the Louisiana Medicaid Fee for Service Pharmacy Program and five Managed Care Organizations (Aetna, AmeriHealth Caritas, Healthy Blue, Louisiana Healthcare Connections, and United Healthcare) **will require** all prescribers to use the *Louisiana Uniform Prescription Drug Prior Authorization Form*. In accordance with Act 423 of the 2018 Legislature, "a prescriber or pharmacy required to obtain prior authorization from a third party payor shall complete the *Louisiana Uniform Prescription Drug Prior Authorization Form or its electronic equivalent*." Prior authorization of specialty drugs could require a different form in order to maintain the necessary information.

The following specifications apply with the implementation of the *Louisiana Uniform Prescription Drug Prior Authorization Form* when submitting pharmacy claims to Medicaid FFS and MCOs.

- Prescribers shall complete in full and fax the *Louisiana Uniform Prescription Drug Prior Authorization Form* to the appropriate Medicaid MCO or FFS pharmacy prior authorization provider.
- The use of the form is a legal requirement and your PA could be denied if the form is not utilized.
- In order to obtain necessary prior authorization processing, the following therapeutic classes shall be considered specialty drugs for Medicaid only prior authorization purposes: Hepatitis C Virus (HCV) Direct-Acting Antiviral (DAA) agents, Palivizumab (Synagis®), multiple sclerosis, Omalizumab (Xolair®) and other monoclonal antibody agents, and Growth Hormones. This is subject to change.

If you have questions about the content of this memo, you may contact the FFS pharmacy help desk by phone at (800) 437-9101.

If you have questions about pharmacy claims billing, you may contact the appropriate plan at their pharmacy help desk listed in the chart.

| **Healthcare Provider** | **Pharmacy Help Desk** | **Pharmacy Help Desk Phone Number** |
|---|---|---|
| Aetna | CVS Health | (855) 364-2977 |
| AmeriHealth Caritas | PerformRx | (800) 684-5502 |
| Fee for Service | DXC Technology | (800) 648-0790 |
| Healthy Blue | Express Scripts | (844) 367-6111 |
| Louisiana Healthcare Connections | CVS Caremark | (800) 311-0543 |
| United Healthcare | Optum Rx | (866) 328-3108 |

Please forward this notice to other providers to assist with notification. Your continued cooperation and support of the Louisiana Medicaid Program efforts to coordinate care and improve health are greatly appreciated.

JS/MBW/GJS

c: Healthy Louisiana Plans
Melwyn B. Wendt
DXC Technology

Enclosures (2)

**John Bel Edwards**
GOVERNOR

**Rebekah E. Gee M.D., MPH**
SECRETARY

# 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**
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
**https://www.uhcprovider.com/en/health-plans-by-state/louisiana-health-plans/la-comm-plan-home/la-cp-pharmacy.html**
Electronic Prior Authorization: https://provider.linkhealth.com/#/

# 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:

| 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.)

| | YES (True) | NO (False) | THE PRESCRIBER ATTESTS TO THE FOLLOWING: |
|---|---|---|---|
| SHORT AND LONG-ACTING OPIOIDS | | | A. A complete **assessment** for pain and function was performed for this patient. |
| | | | 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:_____