John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
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:

Retail Pharmacy Requests

☐ **Magellan Medicaid Administration, 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: 855-242-0802 / Fax: 844-227-9205 / TTY: 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
1-844-521-6942 (M–F 7 a.m.–7 p.m., Sat. 9 a.m.–1 p.m. CT) / Fax: 844-487-9291
CenterX®: Submit through EPIC EMR

☐ **Humana** – Professionally Administered Drugs
Availity.com (registration required)
Phone: 1-866-461-7273 (M–F 7 a.m.–10 p.m. 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: 877-271-6290 / www.UHCprovider.com

Print Reset

Magellan Medicaid Administration

Louisiana Uniform Prescription Drug Prior Authorization Form

Fax this form to 1-800-424-7402

Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). Information contained in this form is Protected Health Information under HIPAA.

SECTION 1: SUBMISSION

Submitted to: _____

Receiver Phone: _____ Receiver Fax: _____ Date: _____

SECTION 2: PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____ Middle Initial: _____

Prescriber NPI: _____ Plan Provider #: _____ Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

Office Contact Name: _____ Contact Phone: _____

SECTION 3: PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____ Middle Initial: _____

Date of Birth: _____ Patient Phone: _____

Sex: ☐ Male ☐ Female ☐ Other ☐ Unknown

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Plan Name (if different from Section 1): _____

Member #: _____ Medicaid #: _____ Plan Provider ID: _____

1. Is the patient currently a hospital inpatient getting ready for discharge?
   ☐ Yes ☐ No Date of Discharge: _____
2. Is the patient being discharged from a psychiatric facility?
   ☐ Yes ☐ No Date of Discharge: _____
3. Is the patient being discharged from a residential substance use facility?
   ☐ Yes ☐ No Date of Discharge: _____
4. Is the patient a long-term care resident?
   ☐ Yes ☐ No

Patient's Full Name: _____

If **Yes**, Facility Name: _____

Facility Phone: _____

5. EPSDT Support Coordinator contact information, if applicable:

EPSDT Support Coordinator First Name: _____

EPSDT Support Coordinator Last Name: _____

EPSDT Support Coordinator Phone: _____

SECTION 4: PRESCRIPTION DRUG INFORMATION

Drug Name: _____ Drug Strength: _____

Dosage Form: _____ Route of Admin.: _____

Quantity: _____ Day Supply: _____ Dosage Interval: _____

Directions for Use: _____

Expected Therapy Duration: _____ Start Date: _____

6. To the best of your knowledge, this medication is the following:

☐ New Therapy/Initial Request ☐ Continuation of Therapy/Reauthorization Request

For Provider-Administered Drugs only:

HCPCS/CPT-4 Code: _____ NDC #: _____

Dose per administration: _____ Other Codes: _____

7. Will the patient receive the drug in the physician's office?

☐ Yes ☐ No

If **No**, list name of Servicing Provider/Facility: _____

If **No**, list NPI of Servicing Provider/Facility: _____

SECTION 5: PATIENT CLINICAL INFORMATION

8. Primary diagnosis relevant to this request: _____

ICD-10 Diagnosis Code: _____ Date diagnosed: _____

9. Secondary diagnosis relevant to this request: _____

ICD-10 Diagnosis Code: _____ Date diagnosed: _____

10. For pain-related diagnoses, pain is the following:

☐ Acute ☐ Chronic

11. For postoperative pain-related diagnoses — Date of Surgery: _____

12. Pertinent laboratory values and dates (attach or list below):

Date: _____ Name of Test: _____ Value: _____

Date: _____ Name of Test: _____ Value: _____

Patient's Full Name: _____

SECTION 6: THIS SECTION FOR OPIOID MEDICATIONS ONLY

13. Does the quantity requested exceed the maximum quantity limit allowed?

    ☐ Yes ☐ No

    If **Yes**, provide justification below (see Section 8: Justification).

14. Cumulative daily MME: _____

15. Does cumulative daily MME exceed the daily maximum MME allowed?

    ☐ Yes ☐ No

    If **Yes**, provide justification below (see Section 8: Justification).

SHORT- AND LONG-ACTING OPIOIDS

The prescriber attests to the following:

16. A complete **assessment** for pain and function was performed for this patient.

    ☐ Yes (true) ☐ No (false)

17. The patient has been **screened for substance abuse/opioid dependence**.
    (Not required for recipients in long-term care facility).

    ☐ Yes (true) ☐ No (false)

18. The **PMP** will be accessed **each** time a controlled prescription is written for this patient.

    ☐ Yes (true) ☐ No (false)

19. A **treatment plan** which includes current and previous goals of therapy for both pain and function has been developed for this patient.

    ☐ Yes (true) ☐ No (false)

20. **Criteria** for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.

    ☐ Yes (true) ☐ No (false)

21. **Benefits and potential harms** of opioid use have been discussed with this patient.

    ☐ Yes (true) ☐ No (false)

22. An **Opioid Treatment Agreement** signed by both the patient and prescriber is on file.
    (Not required for recipients in long-term care facility).

    ☐ Yes (true) ☐ No (false)

LONG-ACTING OPIOIDS

23. The patient requires continuous **around-the-clock** analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.

    ☐ Yes (true) ☐ No (false)

24. Patient previously utilized at least two weeks of short-acting opioids for this condition.

    ☐ Yes (true) ☐ No (false)

    Please enter drug(s), dose, duration, and date of trial in pharmacologic/non-pharmacologic treatment section below (see Section 7).

Patient's Full Name: _____

25. 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.
    ☐ Yes (true) ☐ No (false)

26. Medication has **not** been prescribed for use as on as-needed (PRN) analgesic.
    ☐ Yes (true) ☐ No (false)

27. Prescribing information for the requested product has been **thoroughly reviewed** by prescriber.
    ☐ Yes (true) ☐ No (false)

If **No** for any of the above (#16–27), explain:

SECTION 7: PHARMACOLOGIC & NON-PHARMACOLOGIC TREATMENT(S) USED FOR THIS DIAGNOSIS (BOTH PREVIOUS AND CURRENT)

Drug Name & Strength: _____ Frequency: _____

Dates started and stopped: _____ to _____ or approximate duration: _____

Describe Response, Reason: _____

Drug Name & Strength: _____ Frequency: _____

Dates started and stopped: _____ to _____ or approximate duration: _____

Describe Response, Reason: _____

Drug Name & Strength: _____ Frequency: _____

Dates started and stopped: _____ to _____ or approximate duration: _____

Describe Response, Reason: _____

Drug Allergies: _____

Height (if applicable): _____

Weight (if applicable): _____

28. Is there clinical evidence or patient history that suggests the use of the plan's prerequisite medication(s), e.g., step medications, will be ineffective or cause an adverse reaction to the patient?
    ☐ Yes ☐ No
    If **Yes**, explain in Justification section (see Section 8: Justification).

Patient's Full Name: _____

SECTION 8: JUSTIFICATION (SEE INSTRUCTIONS)

☐ Attachments

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.

Prescriber Signature: _____ **Date:** _____

Mail requests to:

Magellan Medicaid Administration, LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 1-800-424-1664

Fax this form to 1-800-424-7402