John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
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

☐ **Humana**
Phone: 1-866-730-4357 Fax: 1-866-797-2329
www.lamedicaid.com

☐ **LA Healthcare Connections**
Retail Medication Requests:
Phone: 1-888-929-3790 Fax: 1-866-399-0929
Physician Administered Medication Requests (Buy and Bill):
Phone: 1-866-595-8133 Fax: 1-866-925-3006
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/#/

PLEASE CALL IF YOU HAVE ANY PROBLEMS RECEIVING THIS FAX OR IF PAGES ARE MISSING.

LOUISIANA UNIFORM PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

SECTION I — SUBMISSION

Submitted to:	Phone:	Fax:	Date:
Aetna Better Health® of Louisiana	1-855-242-0802	1-844-699-2889	

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:_____