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](http://www.aetnabetterhealth.com/louisiana/providers/pharmacy)

- **AmeriHealth Caritas Louisiana**
  Phone: 1-800-684-5502 Fax: 1-855-452-9131

- **Fee-for-Service (FFS) Louisiana Legacy Medicaid**
  Phone: 1-866-730-4357 Fax: 1-866-797-2329
  [www.lamedicaid.com](http://www.lamedicaid.com)

- **Healthy Blue**
  Phone: 1-844-521-6942 Fax: 1-844-864-7865
  [https://providers.healthybluela.com/la/pages/home.aspx](https://providers.healthybluela.com/la/pages/home.aspx)

- **LA Healthcare Connections**
  Phone: 1-888-929-3790 Fax: 1-866-399-0929

- **United Healthcare**
  Phone: 1-800-310-6826 Fax: 1-866-940-7328

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**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: ____________

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):

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
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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.)

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Strength</th>
<th>Frequency</th>
<th>Dates Started and Stopped or Approximate Duration</th>
<th>Describe Response, Reason</th>
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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 VII - Pharmacologic & non-pharmacologic treatment(s) used for this diagnosis (both previous & current):

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Strength</th>
<th>Frequency</th>
<th>Dates Started and Stopped or Approximate Duration</th>
<th>Describe Response, Reason</th>
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SHORT AND LONG-ACTING OPIOIDS

YES (True)  NO (False)

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 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:____________________