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
   Electronic Prior Authorization: https://provider.linkhealth.com/#/

Please call if you have any problems receiving this fax or if pages are missing.

Bienville Building • 628 N. Fourth St • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Pharmacy Helpdesk Phone: (800) 437-9101
An Equal Opportunity Employer

This facsimile transmission may contain Protected Health Information, Individual Identifiable Health Information and other information which is protected by law. The information is intended only for the use of the intended recipient. If you are not the intended recipient, you are hereby notified that any review, disclosure/re-disclosure, copying, storing, distributing or the taking of action in reliance on the content of this facsimile transmission and any attachments thereto, is strictly prohibited. If you have received this facsimile transmission in error, please notify the sender immediately via telephone and destroy the contents of this facsimile transmission and its attachments.
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>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Allergies:</th>
<th>Height (if applicable):</th>
<th>Weight (if applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: ___________________________