

NOTICE OF INTENT

**Department of Health
Board of Medical Examiners**

**Louisiana Uniform Prescription Drug Prior
Authorization Form
(LAC 46:XLV.8001-8003)**

Notice is hereby given that in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 *et seq.*, pursuant to the authority of the Louisiana Medical Practice Act, R.S. 37:1261 *et seq.*, the Louisiana State Board of Medical Examiners (Board) hereby gives notice of its intent to promulgate a new rule establishing the Louisiana Uniform Prescription Drug Prior Authorization Form. This rule-making effort is required by Act 423, of the 2018 Regular Session of the Legislature, and is in collaboration with the Louisiana Board of Pharmacy. The proposed rule is set forth below.

**Title 46
PROFESSIONAL AND
OCCUPATIONAL STANDARDS
Part XLV. Medical Professions
Subpart 3. Practice**

**Chapter 80. Louisiana Uniform
Prescription Drug Prior Authorization
Form**

Subchapter A. General Provisions

**§8001. Louisiana Uniform Prescription Drug
Prior Authorization; Requirements;
Referral for Enforcement**

A. A prescriber or pharmacy required to obtain prior authorization from a third party payor shall complete the Louisiana Uniform Prescription Drug Prior Authorization Form referenced below in Section 8003, either in written form or its electronic equivalent.

B. In the event a third party payor demands the completion of an alternative authorization process, the prescriber or pharmacy shall refer the demand to the appropriate enforcement agency.

1. If the demand is made by a Medicaid managed care organization, the prescriber or pharmacy shall refer the demand to the Department of Health.

2. If the demand is made by any other third party payor, the prescriber or pharmacy shall refer the demand to the Department of Insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1006.1(C) and 46:460.33(B).

HISTORICAL NOTE: Promulgated by the Department of Health, Board of Medical Examiners, LR

**§8003. Louisiana Uniform Prescription Drug
Prior Authorization Form**

[Form begins on next page]

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:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address:		City:	State:	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
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.)

SHORT AND LONG-ACTING OPIOIDS	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
			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 patient'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: _____

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1006.1(C) and 46:460.33(B).

HISTORICAL NOTE: Promulgated by the Department of Health, Board of Medical Examiners, LR

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of the proposed rule on the family has been considered. It is not anticipated that the proposed rule will have any impact on family, formation, stability or autonomy, as described in R.S. 49:972.

Poverty Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the impact of the proposed rule on those that may be living at or below one hundred percent of the federal poverty line has been considered. It is not anticipated that the proposed rule will have any impact on child, individual or family poverty in relation to individual or community asset development, as described in R.S. 49:973.

Provider Statement

In compliance with HCR 170 of the 2014 Regular Session of the Louisiana Legislature, the impact of the proposed rule on organizations that provide services for individuals with developmental disabilities has been considered. It is not anticipated that the proposed rule will have any impact on the staffing, costs or overall ability of such organizations to provide the same level of services, as described in HCR 170.

Small Business Statement

It is not anticipated that the proposed rule will have any adverse impact on small businesses as defined in the Regulatory Flexibility Act, R.S. 49:965.2 et. seq.

Public Comments

Interested persons may submit written data, views, arguments, information or comments, via United States Postal Service or other mail carrier, or in the alternative, by personal delivery, to Rita Arceneaux, Confidential Executive Assistant, Louisiana State Board of Medical Examiners, 630 Camp Street, New Orleans, Louisiana, 70130, (504) 568-6820, Ex. 242. She is responsible for responding to inquiries regarding the proposed rule.

Public Hearing

A public hearing on this proposed rule is scheduled for Friday, September 28, 2018, at 9:00 a.m., at the office of the Louisiana State Board of Medical Examiners, 630 Camp Street, New Orleans, Louisiana, 70130. At that time, all interested persons will be afforded an opportunity to submit data, views, or arguments, either orally or in writing. The deadline

for the receipt of all comments is 12:00 noon that same day.

Vincent A. Culotta, Jr., M.D.
Executive Director