FAX OR MAIL this form to:
La Medicaid Rx PA Operations
ULM School of Pharmacy
1800 Bienville Drive
Monroe, LA 71201-3765
FAX 866-RX PAFAX
FAX 866-797-2329

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION OVERRIDE

Form: Rx PA16
Issue Date: 3/01/2013
Revised Date: 2/12/2015

Voice Phone:
866-730-4357

Please type or print legibly. Incomplete forms will not be approved.

Date of Request	Number of Fax Pages	
Prescribing Provider Information	**Recipient Information**	
Name (Last, First)	Name (Last, First)	
LA Medicaid Prescribing Provider Number / NPI	LA Medicaid CCN or Recipient Number	
Provider Specialty	Date of Birth (mm/dd/yy)	
Call-Back Phone Number (include area code)	Recipient Weight (kg)	Recipient Height (ft / in)
FAX Number (Include area code)	Medication Allergies	
Office Contact Name	EPSDT Support Coordinator (Name / Address) *(optional)*	

Requested Drug Information

Initiation of Therapy ☐ Continuation of Therapy ☐

Drug Name	Drug Strength	Dosage Form	Dosage Interval (sig)
Diagnosis Code (relevant for this request)		Diagnosis Description	Quantity

This request is for:

☐ **For duration of therapy override**

Diagnosis	
Medical Justification	

☐ **For early refill override**

☐	Medication lost	☐	Physician changed dosage
☐	Medication destroyed	☐	Medication stolen
☐	Patient going out of town for period greater than the day's supply remaining of the previous refill		

Please attach supporting documentation

☐ **For maximum unit / maximum cost / maximum dose / quantity limit override**

Diagnosis	
Medical Justification	

☐ **For therapeutic duplication**

Diagnosis	
Reason for request	☐ Strength / dosage change* ☐ Titration and concomitant therapy**

Drug name and strength_____ Qty_____ Stop date_____

Drug name and strength_____ Qty_____ Stop date_____

Reason for change	

*** Stop date is required for strength / dosage change** **** Attach medical justification if both drugs are to be continued (titration / concomitant therapy)**

Practitioner Signature: _____
(If a signature stamp is used, then the prescribing practitioner must initial the signature.)

Louisiana Fee-For-Service (FFS) Medicaid
Opioid Analgesic Treatment Worksheet

This worksheet must be completed in full and submitted with the Request for Prescription Override (RXPA16) form. Provide supporting documentation where applicable.

Recipient Name:	Medicaid Recipient ID #	Recipient DOB:
Prescriber Name:	Prescriber Specialty:	Medicaid Provider ID # or NPI#:
Call-Back Phone#:	Office Fax#:	Office Contact:

DRUG INFORMATION

DRUG NAME/DOSAGE FORM_____ STRENGTH_____
DIRECTIONS_____ QUANTITY REQUESTED_____
REQUEST IS FOR: ☐ INITIATION OF THERAPY ☐ CONTINUATION OF THERAPY

TREATMENT INFORMATION

1. This medication is being used for: ☐ acute pain ☐ chronic pain
2. Diagnoses for which the opioid is prescribed in greater than a 15-day supply: _____
3. Explain in detail why the opioid quantity exceeds a 15-day supply: _____
4. List other treatments that have been tried for this condition, both pharmacological and non-pharmacological: _____
5. List other opioid analgesics that are to be used concurrently with the requested medication for treatment of pain (if applicable): _____

PRESCRIBER ATTESTATION

6. The prescriber attests to the following:

YES	NO	ATTESTATION
		A complete **assessment** for pain and function was performed for this patient.
		The patient's **risk** for opioid misuse or abuse has been assessed.
		The **PDMP** (Prescription Drug Monitoring Program) will be accessed each time a new prescription is written for this patient.
		A **treatment plan** which includes goals of therapy for both pain and function has been developed for this patient.
		Criteria for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
		Benefits and potential harms of opioid use have been discussed with this patient. In addition, risks of combining opioids with other central nervous system depressants such as benzodiazepines, alcohol, other sedatives, illicit drugs such as heroin, or other opioids have been discussed with this patient.
		An **Opioid Treatment Agreement** signed by both the patient and prescriber is on file.

IF NO FOR ANY OF THE ABOVE, PLEASE EXPLAIN:

YES	NO	ATTESTATION
		Prescriber attests that the patient's cumulative Morphine Equivalent Dose for all current meds is less than 90MED/day.*

IF NO, GIVE MEDICAL JUSTIFICATION FOR THE NEED FOR MORPHINE EQUIVALENT DOSE EQUAL TO OR EXCEEDING 90MED/DAY:

**CDC guidelines recommend that prescribers carefully reassess evidence of individual benefits and risks when considering increasing Morphine Equivalent Dosage to >/= 50MED/day, and that prescribers avoid increasing dosage to >/= 90MED/day or carefully justify the decision to titrate dosage to >/= 90MED/day. Various online Morphine Equivalent Dose calculators are available.*

ADDITIONAL INFORMATION

7. Is the patient currently a resident in a long-term care facility? Yes ☐ No ☐
   If Yes, Facility name: _____ Facility address: _____
   Facility phone number: _____

Prescriber's Signature _____ Date _____
(If a signature stamp is used, then the prescribing practitioner must initial the stamp.)