FAX OR MAIL this form to:
La Medicaid Rx PA Operations
ULM College of Pharmacy
1800 Bienville Drive
Monroe, LA 71201-3765
FAX 866-RX PA FAX
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 PRIOR AUTHORIZATION

Form: Rx PA01
Issue Date: 4/3/2032

Voice Phone:
866-730-4357

*Please type or print legibly (fields followed by an asterisk * are required, all other fields are requested).*

Date of Request:*	Number of Fax Pages: *
Practitioner Information	**Patient Information**
Name*	Name: (Last, First)*
LA Medicaid Prescribing Provider Number/NPI:*	LA Medicaid CCN or Recipient Number*
LA Medicaid Billing Provider Number	Date of Birth (mm/dd/yyyy)* / /
Call-Back Phone Number (include area code)* - -	
FAX Number (include area code)* - -	Projected Duration: *
Requested Drug Information	
Drug Name*	Drug Strength
Diagnosis Code: (ICD -9-CM)			|.				Diagnosis Description: *

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:

1. Has the patient experienced treatment failure with the preferred products? ☐ YES ☐ NO

2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
   If YES, list the condition(s) in the box below:

3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
   If YES, list the interactions(s) in the box below:

4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
   If YES, list the side effects in the box below:

Practitioner Signature:* ____

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

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