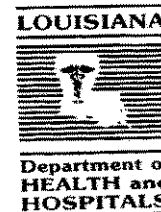


M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



David W. Hood
SECRETARY

September 12, 2003

Dear Pharmacy Provider:

Attached is the complete, most current listing of drugs on the Medicaid Prior Authorization (PA) Process' Preferred Drug List (PDL) "03-05." The listing includes preferred drugs and those drugs requiring prior authorization.

The PA process, in accordance with the program's "Continuity of Care" policy, does not impact original prescriptions (or refills) issued by a prescribing practitioner prior to effective PA dates of drugs as they are added to the PA process *as long as they are within the 5 refills and 6-month program limits*. An educational alert will notify the pharmacist that prescriptions (and their refills) will require a new prescription and prior authorization if the prescription life exceeds six months or the refill exceeds the 5 refill limit. The educational alert will state, "NEW RX WILL REQUIRE PA AFTER (DATE)."

Information on the Prior Authorization process, including the PDL and Prior Authorization Request Form (copy is attached, Form RXPA01), is also available on the Louisiana Medicaid website (www.lamedicaid.com). This website will be updated when changes (additions or deletions) are made to the PDL. The program may also utilize the provider remittance advices to notify providers of PDL changes that must be implemented in short time frames.

The Department has received inquiries that drug products requiring PA are not reimbursable by Medicaid. Medicaid does reimburse for drug products requiring prior authorization when the prior authorization process is followed. Additionally, should a claim deny because a PA is required, you may want to 1) verify that the PA was actually obtained and the dates of service for the PA; 2) verify that the filling date on the claim is subsequent to the start date of the PA. (Remember: PAs are not retroactive); and 3) call the POS help desk for further assistance.

Please note that for drugs available over-the-counter (OTC) shall not be billed to the Medicaid Program with the NDC for the legend product. The OTC NDCs will not be covered by the Department. NDCs of the legend product that remain covered will be subject to PA and POS requirements.

Also, attached is Appendix D detailing the information required to review retroactive eligibility. Please be advised that pharmacy claims will only be overridden for the prior authorization edit for **eligibles with certified retroactive eligibility**. Claims submitted for eligibles who do not have retroactive eligibility will not have the PA edit overridden.

Thank you for your continued cooperation. We appreciate your participation in the Medicaid Program.

Sincerely,

Ben A. Bearden
Medicaid Director

BAB/ht

Attachments (3)

Fax or Mail this form to:
 LA Medicaid Rx PA Operations
 ULM College of Pharmacy
 1401 Royal Avenue
 Monroe, LA 71201
 Fax: 866-RX PA 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 RXPA01
 Issue Date: 3/1/2002

Voice Phone:
 866-730-4357

Please type or print legibly (fields followed with 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:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth (m/d/y):*
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 product(s)? 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 interaction(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:

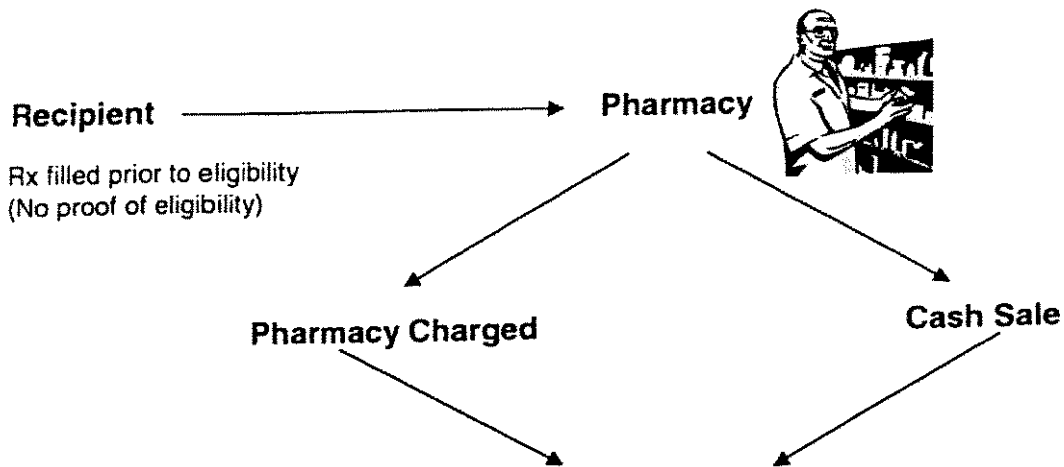
Practitioner Signature:* _____

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

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Appendix D. Retroactive Eligibility Process for Rx PA



Retroactive Eligibility established for Recipient
 ✓ Paper Eligibility **Form 18** processed by DHH
 ✓(Example: Form 18-LTC indicates LTC eligibility. Form 18 does not always certify retroactive eligibility.)
 ✓ Plastic Card issued to recipient with CCN

POS Claim is denied with "PA Required" edit

Scenario 1: Rx credited the Recipient

1. Acct Receivable credited
2. Pharmacy submission of:
 - a. Claim
 - b. Form 18
 - c. Cover letter requesting RxPA override.
- To:
DHH MMIS Unit
P.O. Box 91030
Baton Rouge, LA 70821.
3. PA override applied by DHH.
4. Unisys processes claim.
5. Payment to Pharmacy.

Scenario 2: Recipient paid cash

1. Cash refund to recipient refused.
2. Recipient contacts parish office.
3. Parish office mails pharmacy form RRP-P.
4. Pharmacy completes form RRP-P and returns to parish office.
5. DHH processes form RRP-P
 - a. PA override applied.
 - b. Sent to Unisys for data entry.
6. Payment to Recipient.

Scenario 3: Recipient paid cash (Full cash refund to the Recipient)

1. Full amount cash refund to recipient.
2. Pharmacy submission of:
 - a. Claim
 - b. Form 18
 - c. Cover letter requesting RxPA override.
- To:
DHH MMIS Unit
P.O. Box 91030
Baton Rouge, LA 70821.
3. PA override applied by DHH.
4. Unisys processes claim.
5. Payment to Pharmacy.