Bobby Jindal
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SECRETARY

State of Louisiana

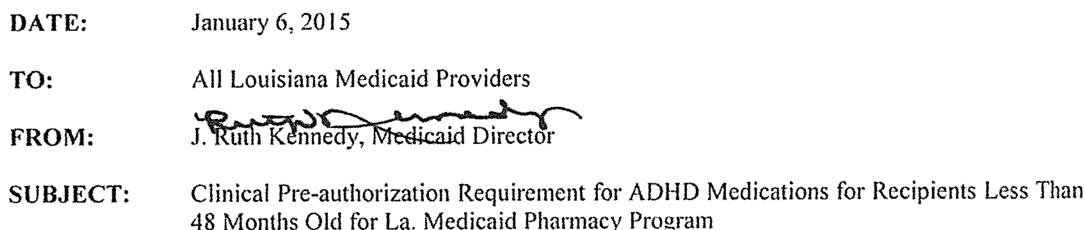
Department of Health and Hospitals
Bureau of Health Services Financing

M E M O R A N D U M

DATE: January 6, 2015

TO: All Louisiana Medicaid Providers

FROM: J. Ruth Kennedy, Medicaid Director



SUBJECT: Clinical Pre-authorization Requirement for ADHD Medications for Recipients Less Than 48 Months Old for La. Medicaid Pharmacy Program

Effective January 21, 2015, the Louisiana Medicaid Pharmacy Program in collaboration with the Louisiana Medicaid Drug Utilization Review (DUR) Board has established clinical pre-authorization criteria for Attention Deficit Hyperactivity Disorder (ADHD) medications for recipients less than 48 months old.

Claims for ADHD medications for recipients less than 48 months old will be reimbursed at Point of Sale (POS) when the prescriber has obtained an approved clinical pre-authorization. Prescribers must complete the Behavioral Health Worksheet in full and fax to 866-797-2329. See complete instructions following this document or refer to www.lamedicaid.com.

Pharmacy claims for these medications will deny at POS with:

> **NCPDP reject code 88 (DUR Reject Error) mapped to**
> **EOB code 066 (Clinical Pre-Authorization Required)**

Override provisions should be addressed through the Clinical Pre-Authorization process.

Compliance associated with program policy will be verified through our Louisiana Medicaid Pharmacy Compliance Audit Program.

Your continued cooperation and support of the Louisiana Medicaid Program efforts to coordinate care and improve health are greatly appreciated.

If you have questions about the contents of this memo, you may contact the Pharmacy Help Desk at (800) 437-9101 or refer to www.lamedicaid.com.

MCJ/MBW/ESF

c: Bayou Health Plans
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Dr. Rebekah Gee
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ADHD Medication Clinical Pre-Authorization Requirements
For Legacy Medicaid and Shared Health Plan Recipients Younger than 48 Months of Age

All prescriptions for ADHD medications for recipients younger than 48 months of age enrolled in Legacy Medicaid and Shared Health plans require clinical pre-authorization. Prescribing providers must complete the Behavioral Medication Therapy Clinical Pre-Authorization form and fax to LA Medicaid RxPA Operations at the University of Louisiana at Monroe School of Pharmacy at 866-797-2329. Prescribing providers will be notified by fax or mail of the outcomes of clinical pre-authorization requests.

Clonidine and Guanfacine

The pharmacy claim will bypass the clinical pre-authorization requirement at point-of-sale for clonidine IR (tablet), clonidine (transdermal), and guanfacine IR with at least one of the following diagnosis codes:

Diagnosis Code	Description
401.00 – 405.99	Hypertensive disease
745 – 747.9	Hypertension in congenital heart disease

Medical Reconsideration

Medical Reconsideration of a denied clinical pre-authorization decision may be requested by the prescribing practitioner. Reconsideration requires completion of the Request for Reconsideration form available at www.lamedicaid.com. The form must be completed in full and signed by the prescribing practitioner. Signature stamps and proxy signatures are not acceptable. The completed form must be faxed from the prescribing practitioner to the LA Medicaid RxPA Operations at the University of Louisiana at Monroe School of Pharmacy at 318-812-2940.

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

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
Behavioral Medication Therapy Clinical Pre-Authorization Form

Issue Date: 12/17/2014
Voice 866-730-4357
Fax 866-797-2329

Note: If this request is for a non-preferred medication, a prior authorization request must also be submitted in addition to this worksheet. Provide supporting documentation where applicable. Complete Sections 1A-1D for initial requests. Complete section 2 for continuation requests.

Complete Section for Initial and Continuation Requests

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) as of (date)
FAX Number (Include area code)	Recipient Height (ft / in) as of (date)
Office Contact Name	Medication Allergies

Requested Drug Information

Initiation of Therapy ☐ Continuation of Therapy ☐

Drug Name	Drug Strength	Dosage Form	Dosage Interval (Sig)

Diagnosis Code(s) [relevant for this request]	Diagnosis Description(s)	Quantity

Section 1: Initial Requests

Section 1A: Non-pharmacologic Interventions Related to this Diagnosis (Attach additional sheets, if necessary)

Intervention	Duration	Outcome

Section 1B: Previous Medication Therapy for this Diagnosis (Attach additional sheets, if necessary)

Drug / Dosage Form / Strength	Start date / End date	Outcome of Therapy	Reason for Discontinuation
	Start Date End Date		
	Start Date End Date		
	Start Date End Date		

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

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
Behavioral Medication Therapy Worksheet

Issue Date: 12/17/2014
Voice 866-730-4357
Fax 866-797-2329

Section 1C: Evaluation and Assessment

Please attach documentation of evaluation and assessment conducted by behavioral health specialist. **OR**

Attest that a systematic evaluation and assessment have been performed by initialing each component of the systematic evaluation listed below:

	Detailed history of symptoms (including symptoms from non-custodial caregivers)
	Evidence that social and lifestyle factors which may influence behavior were considered, addressed, and ruled out
	Documentation of in-office observations (and appointment dates) which support reported behaviors/symptoms
	Documentation of behavior which indicates that the patient is aggressive, posing danger to self and/or others, OR which demonstrates extreme behavior

Section 1D: Baseline Clinical Monitoring Parameters [See chart below for required information.]

Date	Lipid Panel LDL__________ Total cholesterol__________ HDL__________ Triglycerides__________	BMI	Heart rate	B/P
		FBS OR HbA1C		Prolactin

Refer to the therapeutic drug category in the chart below for required clinical monitoring parameters. These parameters are required at baseline, every six months, and with dosage changes.

Required Monitoring Parameters	Alpha-Agonists[1]	Atypical Antipsychotics[2]	Mood Stabilizers[3]	Stimulants[4]	Tricyclic Antidepressants[5]
Blood pressure	✓	✓		✓	
FBS OR HbA1C		✓			
Heart rate	✓			✓	✓
Lipid panel		✓			
Prolactin		✓			
Therapeutic drug monitoring			✓		

[1]Alpha-agonists: some examples include clonidine and guanfacine.
[2]Atypical antipsychotics: some examples include aripiprazole, clozapine, olanzapine, paliperidone, quetiapine, risperidone, and ziprasidone.
[3]Mood stabilizers: some examples include lithium, lamotrigine, valproic acid, divalproex sodium, and carbamazepine.
[4]Stimulants: some examples include dexmethylphenidate, dextroamphetamine, amphetamine, methamphetamine, lisdexamfetamine, methylphenidate, and atomoxetine.
[5]Tricyclic antidepressants: some examples include maprotiline, amitriptyline, clomipramine, desipramine, imipramine, nortriptyline, protriptyline, trimipramine maleate, doxepin, and amitriptyline/chlordiazepoxide.

Section 2: Continuation Requests [See chart above for required information.]

Date	Lipid Panel LDL__________ Total cholesterol__________ HDL__________ Triglycerides__________	BMI	Heart Rate	B/P
		FBS OR HbA1C		Prolactin
Date	Results of therapeutic drug monitoring (if applicable)			
Date	Outcome of drug treatment			

Physician Signature:* ______________________________ **Date:**________________

*(*Signature stamps and proxy signatures are not acceptable.)*

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