John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

MEMORANDUM

DATE: December 14, 2016

TO: All Louisiana Medicaid Providers

FROM: Jen Steele, Medicaid Director

SUBJECT: Louisiana Fee for Service (FFS) Medicaid Pharmacy Opioid Quantity Limits (Updated)

Effective January 10, 2017, the Louisiana Department of Health Pharmacy Program in conjunction with the Louisiana Medicaid Drug Utilization Review (DUR) Board has revised quantity limits for selected opioid products (See exceptions noted below).

Pharmacy claims exceeding the limits listed in the table below will deny at Point of Sale (POS) with:

NCPDP reject code 76 (Quantity and/or days' supply exceeds program maximum) mapped to
EOB code 153 (Quantity Exceeds Max-MD Fax Override Form to 866-797-2329)

Overrides for quantities greater than the limits listed in the table below will be addressed using the Request for Prescription Override Form (Rx PA16) with an Opioid Analgesic Treatment Worksheet. The prescriber must fax the completed forms and applicable supporting documentation to the Prior Authorization Unit housed at University of Louisiana (ULM) at (866) 797-2329.

Revised Opioid Quantity Limits, Units per 15 Days Supply within a 30 day period			
Description	**Dosage Form**	**Units / 15 days**	**Representative Brand**
Hydrocodone Bitartrate, Hydrocodone/Ibuprofen	Capsule ER 12 hr, Tablet	**30 units**	Zohydro ER®, Vicoprofen®
Hydrocodone Bitartrate	Tablet ER 24 hr	**15 units**	Hysingla ER®
Hydrocodone/Acetaminophen	Short Acting Tablet/Capsule	**45 units**	Lortab®, Vicodin®
Hydromorphone HCl	Short Acting Tablet	**45 units**	Dilaudid®
Hydromorphone HCl	Tablet ER 24 hr	**15 units**	Exalgo®

Meperidine	Tablet	**45 units**	Demerol®
Methadone	Tablet	**45 units**	
Morphine Sulfate	Tablet	**45 units**	
Morphine Sulfate	Capsule ER 24 hr	**15 units**	Avinza®
Morphine Sulfate	Capsule SR Pellet, Tablet SA	**30 units**	Kadian®, MS Contin®
Morphine Sulfate/Naltrexone	Capsule SR Pellet	**30 units**	Embeda®
Oxycodone HCl, Oxycodone, Oxycodone/Acetaminophen	Tablet SR 12 hr, Capsule ER 12 hr Tablet ER 12 hr	**30 units**	Oxycontin® Xtampza ER® Xartemis XR®
Oxycodone HCl, Oxycodone/Acetaminophen, Oxycodone/Aspirin	Tablet/Capsule	**45 units**	Roxicodone®, Endocet®, Percocet®, Roxicet®
Oxycodone/Ibuprofen	Tablet	**14 units**	
Oxymorphone HCl	Tablet	**45 units**	Opana®
Oxymorphone HCl	Tablet SR 12 hr	**30 units**	Opana ER®
Tapentadol	Tablet	**45 units**	Nucynta®
Tapentadol	Tablet ER 12 hr	**30 units**	Nucynta ER®
Tramadol HCl	Tablet	**45 units**	Ultram®
Tramadol HCl	Tablet ER 24 hr Capsule ER 24 hr	**15 units**	Ultram ER® ConZip®
Tramadol/Acetaminophen	Tablet	**40 units**	Ultracet®

Fentanyl Transdermal Patch Quantity Limits- Units per 30 Rolling Day Period					
Description	**Dosage Form**	**Route**	**Strength**	**Units/30 Rolling Days**	**Representative Brand**
Fentanyl	Patch	Transdermal	12, 25, 37.5, and 50 mcg/hr	10 units	Duragesic®
Fentanyl	Patch	Transdermal	62.5, 75, 87.5, and 100 mcg/hr	20 units	Duragesic®

Exception: All Schedule II opioid prescriptions require a valid diagnosis code to process. Pharmacy claims for opioid products will not be subject to these quantity limits when one of the diagnosis codes below is submitted. Acceptable diagnosis codes that will bypass this edit when submitted in NCPDP field 424-DO:

Diagnosis Code	Description
C00.*-C96.*	Cancer
Z51.5	Palliative Care
* - any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code	

If a Medicaid FFS recipient is currently exceeding the quantity limits, and the benefits do not outweigh harms of continued opioid therapy, prescribers should work with patients to taper opioids to lower dosages. The Centers for Disease Control (CDC) provides tapering guidelines at http://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf.

Please forward this notice to other providers to assist with notification. The Department's ultimate goal is to ensure appropriate and medically necessary utilization of opioids while decreasing the risk of overutilization and diversion.

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 Molina Point of Sale (POS) Help Desk (800) 648-0790 or Fee for Service (FFS) Pharmacy Help Desk at (800) 437-9101 or refer to www.lamedicaid.com.

SK/MBW/ESF

c: Healthy Louisiana Plans
Melwyn B. Wendt
Molina

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.)