Bobby Jindal
GOVERNOR

Kathy H. Kliebert
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: April 21, 2014

TO: All Louisiana Medicaid Providers

FROM: J. Ruth Kennedy, Medicaid Director

SUBJECT: Additional Limits on Hydrocodone-Containing Drugs

The Louisiana Medicaid Pharmacy Program in collaboration with the Louisiana Medicaid Drug Utilization Review (DUR) Board has established additional limits on hydrocodone containing drugs effective May 1, 2014.

Pharmacy claims for hydrocodone containing drugs will be limited to 720 units in a rolling 365 days. These limits are in **addition** to the current limits. Claims submitted over this limit will deny at Point of Sale (POS) with:

NCPDP rejection error 76 (Quantity and/or days supply exceeds program maximum) mapped to
EOB Code 052 (> 12 Month Quantity Limit)

Overrides for quantities greater than 720 units/365 calendar days will be addressed using an Override Request Form (Rx PA16) and through contact with staff at the Prior Authorization Unit housed at University of Louisiana (ULM).

Exception: Claims for hydrocodone products should not be subject to quantity limits when an acceptable diagnosis is submitted in NCPDP field 424-DO. Acceptable diagnosis codes that will bypass this edit are:

Diagnosis Code (ICD-9)	Description
140-208.99 209.0-209.39	Cancer
282.6-282.69	Sickle-cell

To accurately determine which prescriptions should be exempt, we are requiring the diagnosis code to be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. 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, send a fax to (225) 342-1980, or refer to www.lamedicaid.com

MCJ/MBW/ESF

c: Bayou Health Plans
Dr. Rochelle Dunham
Dr. Rebekah Gee
Dr. James Hussey
Magellan of Louisiana
Molina
Melwyn B. Wendt

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 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

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

Requested Drug Information

Initiation of Therapy ☐ Continuation of Therapy ☐		Projected Duration of Treatment	
Drug Name	Drug Strength	Dosage Form	Dosage Interval (sig)
Diagnosis Code (ICD -9-CM) [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 / 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.)