John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

MEMORANDUM

DATE: June 18, 2019

TO: All Louisiana Medicaid Prescribing Providers and Pharmacists

FROM: Jen Steele, Medicaid Director

SUBJECT: Updated Single Preferred Drug List (PDL) for Acne Treatment Agents

Effective July 1, 2019, the Louisiana Medicaid Fee for Service (FFS) Pharmacy Program and Managed Care Organizations (MCOs) will update the Single Preferred Drug List (PDL). The Single PDL applies to FFS and Medicaid MCOs (Aetna, AmeriHealth Caritas, Healthy Blue, Louisiana Healthcare Connections, and United Healthcare). The updated Single PDL will include acne treatment agents which will be payable for recipients less than 21 years of age.

Preferred and Non-Preferred Acne Treatment Agents
All acne agents will require a clinical authorization. Reimbursement for acne agents will require prescribers to complete in full and submit the *Louisiana Uniform Prescription Drug Prior Authorization Form.*

Refer to http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf for the Single PDL, which is inclusive of the listing for preferred/non-preferred acne treatment agents, criteria, and the *Louisiana Uniform Prescription Drug Prior Authorization Form.*

If you have questions about the content of this memo, you may contact the FFS pharmacy help desk by phone at (800) 437-9101.

If you have questions about pharmacy claims billing, you may contact the appropriate plan at their pharmacy help desk listed in the chart below.

Healthcare Provider	**Pharmacy Help Desk**	**Pharmacy Help Desk Phone Number**
Aetna	CVS Health	(855) 364-2977
AmeriHealth Caritas	PerformRx	(800) 684-5502
Fee for Service	DXC Technology	(800) 648-0790
Healthy Blue	CVS	(833) 236-6194
Louisiana Healthcare Connections	CVS Caremark	(800) 311-0543
United Healthcare	Optum Rx	(866) 328-3108

Please forward this notice to other providers to assist with notification. Your continued cooperation and support of the Louisiana Medicaid Program efforts to coordinate care and improve health are greatly appreciated.

JS/MBW/GJS

c: Healthy Louisiana Plans
Melwyn B. Wendt
DXC Technology

Louisiana Fee-for-Service Medicaid
Acne Agents, Topical

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request authorization for acne agents, topical (preferred and non-preferred). Tazarotene, when used for a diagnosis of psoriasis, will bypass (be exempt from) the authorization process. The diagnosis code for psoriasis (L40*) must be communicated to the pharmacy in order to be submitted on the pharmacy claim.

* Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10 diagnosis code.

Requests to initiate treatment must meet ALL of the following criteria for a diagnosis of acne:

- The recipient is less than 21 years of age on the date of the request; **AND**
- The severity is Grade 3 moderately severe nodulocystic acne (numerous papules and pustules; the occasional inflamed nodule; the back and chest may also be affected) or Grade 4 severe nodulocystic acne (numerous large, painful pustules and nodules; inflammation); **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has a *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that would limit the use of the requested medication and will not be receiving the requested medication in combination with any medication that is contraindicated or not recommended per FDA labeling.

Requests to continue treatment or for reauthorization must meet the following criteria:

- The recipient continues to meet all initial criteria with improved disease severity; **AND**
- The request states the current acne severity, which is an improvement from baseline.

Duration of initial and reauthorization approval for acne: 12 months (or up to the recipient's 21st birthday, whichever is less)

References

Tazorac gel (tazarotene) [package insert]. Madison, NJ: Allergan USA, Inc.; 2018. Retrieved from https://www.allergan.com/assets/pdf/tazorac_gel_pi

Tazarotene cream [package insert]. Hawthorne, NY: Taro Pharmaceuticals U.S.A., Inc.; 2017. Retrieved from https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=34d79c31-1568-4797-a4f5-31200c7788db&type=display

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. *Pharmacotherapy: A Pathophysiologic Approach, 10e* New York, NY: McGraw-Hill; Retrieved from https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; Retrieved from https://www.clinicalkey.com/pharmacology/

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PRIOR AUTHORIZATION REQUEST COVERSHEET

Please check the member's appropriate health plan listed below:

☐ **Aetna Better Health of Louisiana**
Phone: 1-855-242-0802 Fax: 1-844-699-2889
www.aetnabetterhealth.com/louisiana/providers/pharmacy

☐ **AmeriHealth Caritas Louisiana**
Phone: 1-800-684-5502 Fax: 1-855-452-9131
www.amerihealthcaritasla.com/pharmacy/index.aspx

☐ **Fee-for-Service (FFS) Louisiana Legacy Medicaid**
Phone: 1-866-730-4357 Fax: 1-866-797-2329
www.lamedicaid.com

☐ **Healthy Blue**
Phone: 1-844-521-6942 Fax: 1-844-864-7865
https://providers.healthybluela.com/la/pages/home.aspx

☐ **LA Healthcare Connections**
Phone: 1-888-929-3790 Fax: 1-866-399-0929
www.louisianahealthconnect.com/for-members/pharmacy-services/

☐ **United Healthcare**
Phone: 1-800-310-6826 Fax: 1-866-940-7328
https://www.uhcprovider.com/en/health-plans-by-state/louisiana-health-plans/la-comm-plan-home/la-cp-pharmacy.html
Electronic Prior Authorization: https://provider.linkhealth.com/#/

LOUISIANA UNIFORM PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

SECTION I — SUBMISSION

Submitted to:	Phone:	Fax:	Date:

SECTION II — PRESCRIBER INFORMATION

Last Name, First Name MI:		NPI# or Plan Provider #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION III — PATIENT INFORMATION

Last Name, First Name MI:	DOB:	Phone:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:
Plan Name (if different from Section I):	Member or Medicaid ID #:	Plan Provider ID:	

Patient is currently a hospital inpatient getting ready for discharge? ____ Yes ____ No Date of Discharge:_____
Patient is being discharged from a psychiatric facility? ____ Yes ____ No Date of Discharge:_____
Patient is being discharged from a residential substance use facility? ____ Yes ____ No Date of Discharge:_____
Patient is a long-term care resident? ____ Yes ____ No If yes, name and phone number:_____
EPSDT Support Coordinator contact information, if applicable:

SECTION IV — PRESCRIPTION DRUG INFORMATION

Requested Drug Name:

Strength:	Dosage Form:	Route of Admin:	Quantity:	Days' Supply:	Dosage Interval/Directions for Use:	Expected Therapy Duration/Start Date:

To the best of your knowledge this medication is: _____New therapy/Initial request
_____Continuation of therapy/Reauthorization request

For Provider Administered Drugs only:

HCPCS/CPT-4 Code:_____NDC#:_____Dose Per Administration:_____

Other Codes:_____

Will patient receive the drug in the physician's office? ____Yes ____No

– If no, list name and NPI of servicing provider/facility: _____

SECTION V — PATIENT CLINICAL INFORMATION

Primary diagnosis relevant to this request:	ICD-10 Diagnosis Code:	Date Diagnosed:
Secondary diagnosis relevant to this request:	ICD-10 Diagnosis Code:	Date Diagnosed:

For pain-related diagnoses, pain is: _____Acute _____Chronic
For postoperative pain-related diagnoses: Date of Surgery_____

Pertinent laboratory values and dates (attach or list below):

Date	Name of Test	Value

SECTION VI - This Section For Opioid Medications Only

Does the quantity requested exceed the max quantity limit allowed? ___Yes ___No (If yes, provide justification below.)
Cumulative daily MME_____

Does cumulative daily MME exceed the daily max MME allowed? ___Yes ___No (If yes, provide justification below.)

	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
SHORT AND LONG-ACTING OPIOIDS			A. A complete **assessment** for pain and function was performed for this patient.
			B. The patient has been **screened for substance abuse / opioid dependence**. *(Not required for recipients in long-term care facility.)*
			C. The **PMP** will be accessed **each** time a controlled prescription is written for this patient.
			D. A **treatment plan** which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			E. **Criteria** for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			F. **Benefits and potential harms** of opioid use have been discussed with this patient.
			G. An **Opioid Treatment Agreement** signed by both the patient and prescriber is on file. *(Not required for recipients in long-term care facility.)*
LONG-ACTING OPIOIDS			H. The patient requires continuous **around the clock** analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			I. Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in pharmacologic/non-pharmacologic treatment section below.
			J. Medication has **not** been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			K. Medication has **not** been prescribed for use as an as-needed (PRN) analgesic.
			L. Prescribing information for requested product has been **thoroughly reviewed** by prescriber.

*IF NO FOR **ANY** OF THE ABOVE (A-L), PLEASE EXPLAIN:*

SECTION VII - Pharmacologic & non-pharmacologic treatment(s) used for this diagnosis (both previous & current):

Drug name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Is there clinical evidence or patient history that suggests the use of the plan's pre-requisite medication(s), e.g. step medications, will be ineffective or cause an adverse reaction to the patient? ____Yes ____No (If yes, please explain in Section VIII below.)

SECTION VIII — JUSTIFICATION (SEE INSTRUCTIONS)

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Signature of Prescriber:_____ Date:_____