John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

PRIOR AUTHORIZATION REQUEST COVERSHEET

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

Retail Pharmacy Requests

☐ **Magellan Medicaid Administration, LLC**
For Aetna Better Health of Louisiana, AmeriHealth Caritas Louisiana, Healthy Blue, Humana, LA Healthcare Connections, United Healthcare
Phone: 1-800-424-1664 / Fax: 1-800-424-7402

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

Requests for Medications Through Medical Benefit

☐ **Aetna Better Health of Louisiana** – Medical Benefit – Physician Administered Drugs
Phone: 855-242-0802 / Fax: 844-227-9205 / TTY: 855-242-0802, 711

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

☐ **Healthy Blue** – Medical Injectables
1-844-521-6942 (M–F 7 a.m.–7 p.m., Sat. 9 a.m.–1 p.m. CT) / Fax: 844-487-9291
CenterX®: Submit through EPIC EMR

☐ **Humana** – Professionally Administered Drugs
Availity.com (registration required)
Phone: 1-866-461-7273 (M–F 7 a.m.–10 p.m. CT) / Fax: 1-888-447-3430 / (request form at Humana.com/medPA)

☐ **LA Healthcare Connections** – Physician Administered Medication (Buy and Bill)
Phone: 1-866-595-8133 / Fax: 1-866-925-3006

☐ **United Healthcare** – Medical Benefit
Phone: 1-888-397-8129 / Fax: 877-271-6290 / www.UHCprovider.com

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PLEASE CALL IF YOU HAVE ANY PROBLEMS RECEIVING THIS FAX OR IF PAGES ARE MISSING

Direct-Acting Antiviral (DAA) Agents
Used to Treat Chronic Hepatitis C Virus (HCV)
Medication Therapy Worksheet for Louisiana Medicaid Recipients

Note: This worksheet must be completed in full and submitted with supporting documentation where applicable. (See DAA Clinical Authorization Criteria.) Information contained in this form is Protected Health Information under HIPAA.

SECTION 1: PATIENT INFORMATION

Patient Last Name: ______________________________

Patient First Name: ______________________________ Middle Initial: ______

Date of Birth: ____________________ Medicaid Recipient #: ____________________

Patient Weight: ____________________

SECTION 2: PRESCRIBER INFORMATION

Prescriber Last Name: ______________________________

Prescriber First Name: ______________________________ Middle Initial: ______

Prescriber NPI: ____________________ Medicaid Provider #: ____________________

Prescriber Phone: ____________________ Prescriber Fax: ____________________

Prescriber Specialty: ______________________________

Office Contact Name: ____________________ Contact Phone: ____________________

SECTION 3: MEDICATION REGIMEN REQUESTED

Choose one:

- ☐ Elbasvir / Grazoprevir (Zepatier®)
- ☐ Glecaprevir / Pibrentasvir (Mavyret®)
- ☐ Ledipasvir / Sofosbuvir (Harvoni®)
- ☐ Ombitasvir / Paritaprevir / Ritonavir with Dasabuvir (Viekira Pak®)
- ☐ Ledipasvir / Sofosbuvir (Authorized Generic [AG] of Harvoni®)
- ☐ Sofosbuvir / Velpatasvir (Epclusa®)
- ☐ Sofosbuvir (Sovaldi®)
- ☐ Sofosbuvir / Velpatasvir / Voxilaprevir (Vosevi®)
- ☐ Sofosbuvir / Velpatasvir (Authorized Generic [AG] of Epclusa®)
  (This form is not necessary because Epclusa® AG is preferred and does not require authorization.)

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Patient's Name: ______________________________

SECTION 4: CLINICAL CRITERIA

1. Duration of therapy requested: _________ weeks
   (If duration is greater than minimum duration stated per prescribing information, provide rationale below for extended duration.)
2. Reason for extended duration request (if applicable):
   ____
3. Does patient have a diagnosis of Chronic Hepatitis C (HCV)?
   ☐ Yes ☐ No
   Please specify genotype: ______________________________
4. Is patient treatment-naïve?
   ☐ Yes ☐ No
   If **No**, provide previous HCV therapy: ______________________________
5. Was previous therapy completed?
   ☐ Yes ☐ No
   If **No**, provide reason for discontinuation: ______________________________
6. Has the patient experienced treatment failure with the preferred product?
   ☐ Yes ☐ No
7. Has the patient had an intolerable side effect with the preferred product?
   ☐ Yes ☐ No
   If **Yes**, explain in detail: ______________________________
8. Does the patient have documented contraindication(s) to the preferred product?
   ☐ Yes ☐ No
   If **Yes**, explain in detail: ______________________________
9. If there is no preferred product that is appropriate to use for the condition being treated, explain in detail:

By signing below, 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.

Prescriber Signature: ______________________________ **Date:** ____________________

(Signature stamps and proxy signatures are not acceptable.)

Mail requests to:

Magellan Medicaid Administration, LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 1-800-424-1664

Fax this form to 1-800-424-7402