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

Print Reset

Magellan Medicaid Administration

Direct-Acting Antiviral (DAA) Agents Used to Treat Chronic Hepatitis C Virus (HCV)

Treatment Agreement for Louisiana Medicaid Recipients

Prescriber Instructions: Please submit the completed treatment agreement with the initial clinical authorization request for the **non-preferred** Direct-Acting Antiviral Agent(s) (DAA) for Hepatitis C.

SECTION 1: PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____ Middle Initial: _____

Date of Birth: _____ Medicaid Recipient ID #: _____

Hepatitis C Medication Regimen: _____

SECTION 2: PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____ Middle Initial: _____

Prescriber NPI: _____ Medicaid Provider ID #: _____

Prescriber Phone: _____ Prescriber Fax: _____

Office Contact Name: _____ Contact Phone: _____

SECTION 3: PATIENT TREATMENT AGREEMENT

Patient Instructions: Please read this treatment agreement carefully. Please initial each item to show you have read and understand it. Be sure to ask any questions you have before you sign it. Sign and date at the end of the form (page 2).

1. I have been told how to take my hepatitis C medicines. I understand how to take them. I am aware of possible side effects. I understand why it is important to finish all the therapy.

   Patient's Initials: _____

2. I will take my hepatitis C medicines like my doctor said. I will not miss doses.

   Patient's Initials: _____

3. I will tell my doctor and pharmacist the medicines I take. I understand there may be some medicines I cannot take with my hepatitis C medicines.

   Patient's Initials: _____

4. If I am taking ribavirin, I am (**Or** my female partner is) not pregnant.

   Patient's Initials: _____

5. If I am taking ribavirin, I am (**Or** my female partner is) not planning on getting pregnant while I am on my hepatitis C medicines and for at least 6 months after I finish them.

   Patient's Initials: _____

Patient's Name: _____

6. If I am taking ribavirin, I (**Or** my female partner) will use two forms of effective contraception while I am taking my hepatitis C medicines and for at least 6 months after I finish them.

   Patient's Initials: _____

7. If I am taking ribavirin, I (**Or** my female partner) will have monthly pregnancy testing while I am taking my hepatitis C medicines.

   Patient's Initials: _____

I have read the above statements and understand the agreement.

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____