Louisiana Medicaid
Medically Necessary Criteria

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical override for the use of medications outside of the established Point-of-Sale edits, such as diagnosis and quantity limits. The request will be reviewed by a clinician to determine approval status, based upon clinical information provided to support approval of the request.

Additional Point-of-Sale edits may apply to individual agents.

Approval Criteria for Medically Necessary Justification

- The requested medication is being used for a medically accepted indication, age, and dosage as defined using the following sources [Source(s) are **stated on the request**]:
  - Food and Drug Administration (FDA); **OR**
  - Micromedex; **OR**
  - American Hospital Formulary Service (AHFS); **OR**
  - Drug-specific prescribing information (PI); **OR**
  - Disease state specific standard of care guidelines; **OR**
  - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; **AND**
- For non-preferred agents, the recipient must meet **ONE** of the following**:**
  - Documented trial and failure or intolerance with at least one preferred product used to treat the documented diagnosis. For therapeutic categories with only one preferred product, the preferred product must have been ineffective or not tolerated; **OR**
  - No other preferred product has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia; **OR**
  - All other preferred products are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy; **AND**
- By submitting the authorization request, the prescriber attests to the following:
  - This medication is medically necessary for the diagnosis, age, and dosage requested; **AND**
  - The prescriber is aware that the safety edits were developed based upon the contents of the prescribing information, which 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 limit the use of the requested medication and will not receive the requested medication in combination with any medication that is contraindicated or not recommended per FDA labeling.

Duration of initial authorization approval: 6 months

Reauthorization Criteria

- The recipient continues to meet initial approval criteria; **AND**
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of reauthorization approval: 12 months

References

AHFS drug information essentials. Bethesda, MD: American Society of Health-System Pharmacists. Available at www.ahfsdruginformation.com

Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com

U.S. Food and Drug Administration. Center for Drug Evaluation and Research. (2020) Available at www.fda.gov

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