Louisiana Medicaid
Pain Management – Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request prior authorization for non-preferred NSAIDs.

Additional Point-of-Sale edits may apply.

*These agents may have **Black Box Warnings** and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.*

Approval Criteria for Initial and Reauthorization Requests

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- If the request is for a non-preferred combination product (Duexis® or Vimovo®), there is a documented inability to use separate preferred products in the therapeutic classes represented by the individual active ingredients in the requested non-preferred combination product; **AND**
- ~~If the request is for celecoxib (Celebrex®):~~
  - ~~The recipient is 60 years of age or older on the date of the request; **OR**~~
  - ~~**ONE** of the following is true and is **stated on the request**:~~
    - ~~The recipient has a current prescription for a histamine (H_2) receptor antagonist; **OR**~~
    - ~~The recipient has a current prescription for a proton pump inhibitor; **OR**~~
    - ~~The recipient has a current prescription for an oral or injectable anticoagulant; **OR**~~
    - ~~The recipient has a current prescription for at least a 30-day supply of an oral steroid (indicating chronic use); **OR**~~
    - ~~The reason a COX-2 selective agent is used rather than a non-selective NSAID (e.g. history of a GI bleed); **AND**~~
- The requested medication has been prescribed for an approved diagnosis (if applicable); **AND**
- Previous use of a preferred product - **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 *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 limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Duration of initial and reauthorization approval: 12 months

References

~~Celebrex (celecoxib) [package insert]. New York, NY: G.D. Searle LLC; April 2021. http://labeling.pfizer.com/showlabeling.aspx?id=793~~

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

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

Revision / Date	**Implementation Date**
Single PDL Implementation	May 2019
Added wording for Ketorolac maximum quantity limit and day supply at POS / August 2019	January 2020
Added specific wording for use of Voltaren® Gel, separated "Select Therapeutic Classes Not Established" into individual therapeutic class documents / November 2019	January 2020
Removed POS information from document and reference for Ketorolac, removed wording requiring use of preferred brand name Voltaren® Gel and reference, formatting changes / July 2020	July 2020
Added wording for celecoxib, verified references are current / September 2020	January 2021
Formatting changes, updated references / September 2021	January 2022
Removed wording for celecoxib / November 2023	January 2024