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.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation and Continuation of Therapy

- 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**~~**OR**
- If the request is for Vyscoxa™, patient-specific, clinically significant justification as to why the generic capsule formulation of celecoxib cannot be used is **stated on the request**; **AND**
- Trial of **ALL** preferred products~~**ONE of the following**~~ is required~~:~~. ~~–~~Results for each trial must be **stated on the request** and may include treatment failure, intolerable side effects, documented contraindications, and/or the preferred product(s) are inappropriate to use for the condition being treated.
- ~~Previous use of~~ **a** ~~**ALL** preferred products – ONE trial of **the following**~~**ALL** ~~preferred products is required:~~, ~~and the **results of the trial of each preferred product are stated on the request**. Results may include:~~
  - ~~The recipient has had a *treatment failure* with **at least one or more** preferred products; **OR***~~
  - ~~The recipient has had an *intolerable side effect* to **one or more** at least one preferred products; **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.~~

Duration of approval for initiation and continuation of therapy: 12 months

References

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
Removed criterion for diagnosis requirement, formatting changes / February 2025	March 2025
Added criterion for Vyscoxa™ / February 2026	July 2026
Added required trial of all preferred products / March 2026	July 2026