Louisiana Health Access Program
CLAIMS AUTHORIZATION REQUEST FORM
Version 8.1

Provider Services: 888-311-7632
Fax Form to: 800-848-4241
or 510-587-2799

*PLEASE REVIEW REQUEST FOR ACCURACY AND COMPLETE ALL APPROPRIATE FIELDS! **To be completed by the Pharmacy***

PHARMACY INFORMATION

NPI: ____________________

CONTACT PERSON: ____________________
STAMP or **WRITE** Pharmacy Name, Phone & Fax:

PHONE: ( ) ____________________

FAX: ( ) ____________________

CLIENT INFORMATION
(Print Clearly)

____
Last Name First Name

I.D.: ____________________

D.O. B. _______ / _______ / _______

MUST CHECK ALL THAT APPLY
PROOF OF BILLING MUST ACCOMPANY THIS REQUEST

Program Limits
- ☐ Claim over 90 days

Plan Limits
- ☐ ARV Daily QTY Max
  ***Submit rational of exceeding the recommended daily dose in the exception explanation section below.*
- ☐ Day supply less than minimum required
- ☐ Lost med fill
- ☐ Vacation Supply
- ☐ Change in dose* **original Rx required*

Clinical Limits
- ☐ ARV Duplicate Therapy
  ***Submit rational of duplicate therapy in the exception explanation section below.*
- ☐ ARV Contraindicated Therapy
  ***Submit rational of contraindicated therapy in the exception explanation section below.*

All Claims over 90 days will be denied.

RX#	NDC	Copay or Cash Price	Requested QTY	Days Supply	OCC	Rx Fill Date
RX#1 _______	NDC : _____-_____-_____	$: _______		_______		_______
RX#2 _______	NDC : _____-_____-_____	$: _______		_______		_______
RX#3 _______	NDC : _____-_____-_____	$: _______		_______		_______
RX#4 _______	NDC : _____-_____-_____	$: _______		_______		_______
RX#5 _______	NDC : _____-_____-_____	$: _______		_______		_______
RX#6 _______	NDC : _____-_____-_____	$: _______		_______		_______
RX#7 _______	NDC : _____-_____-_____	$: _______		_______		_______
RX#8 _______	NDC : _____-_____-_____	$: _______		_______		_______

Notes/Explanation: