



Louisiana Board of Pharmacy

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October 25, 2018

Senator John A Alario Jr., President
Louisiana Senate
Via Email: APA.SenatePresident@legis.la.gov

Electronic Mail – Delivery Receipt Requested

Re: Report No. 2 of 3 for Regulatory Project 2018-2 ~ Louisiana Uniform Prescription Drug Prior Authorization Form

Dear Senator Alario:

As we indicated in our first report to you on August 10, the Board of Pharmacy is collaborating with the Board of Medical Examiners to promulgate a single uniform prescription drug prior authorization form for use by all payors in the state. This regulatory project was mandated by Act 423 of the 2018 Legislature. Subsequent to our *Notice of Intent* published in the August 2018 edition of the Louisiana Register, we conducted a joint public hearing with the medical board on September 28 to receive comments and testimony on the proposed rule and form.

We received two letters asking questions and offering recommendations for changes in the proposed form. The Board has replied to the commentators and determined that no changes to the proposed rule or form are necessary.

You should find the following documents in this package:

- *Notice of Intent*, as published in the August 2018 Louisiana Register Page 2
- Summary of Comments from September 28 Public Hearing Page 8
- Transcript from September 28 Public Hearing Page 9
- Comments and Board replies to commentators Page 69
- Full text of proposed rule Page 76

Subject to review by the Joint Legislative Oversight Committee on Health & Welfare, the Board proposes to publish the original proposed rule and form as a *Final Rule* in the December 20, 2018 edition of the Louisiana Register with a delayed effective date of January 1, 2019. If you have any questions about the enclosed information or our procedures, please contact me directly at mbroussard@pharmacy.la.gov or 225.925.6481.

For the Board:

Malcolm J. Broussard
Executive Director

cc: Chair, Senate Committee on Health and Welfare – APA.S-H&W@legis.la.gov
Speaker, House of Representatives – APA.HouseSpeaker@legis.la.gov
Chair, House Committee on Health and Welfare – APA.H-HW@legis.la.gov
Editor, Louisiana Register – Reg.Submission@la.gov
Reference File

NOTICE OF INTENT

**Department of Health
Board of Pharmacy**

**Uniform Prescription Drug Prior Authorization Form
(LAC 46:LIII.1129 and 1130)**

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950 et seq.) and the Pharmacy Practice Act (R.S. 37:1161 et seq.), the Louisiana Board of Pharmacy hereby gives notice of its intent to promulgate a new rule to establish the Louisiana Uniform Prescription Drug Prior Authorization Form. The Rule will require all pharmacies, prescribers, and third-party payors to use this form when prior authorizations for prescription drugs are required. This rulemaking activity is required by Act 423 of the 2018 Legislature and is in collaboration with the Louisiana State Board of Medical Examiners.

Title 46

**PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part LIII. Pharmacists

Chapter 11. Pharmacies

Subchapter B. Pharmacy Records

**§1129. Louisiana Uniform Prescription Drug Prior
Authorization Form; Requirements; Referral
for Enforcement**

A. A prescriber or pharmacy required to obtain prior authorization from a third party payor shall complete the Louisiana Uniform Prescription Drug Prior Authorization Form referenced below in Section 1130, either in written form or its electronic equivalent.

B. In the event a third party payor demands the completion of an alternative authorization process, the prescriber or pharmacy shall refer the demand to the appropriate enforcement agency.

1. If the demand is made by a Medicaid managed care organization, the prescriber or pharmacy shall refer the demand to the Dept. of Health.

2. If the demand is made by any other third party payor, the prescriber or pharmacy shall refer the demand to the Dept. of Insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1006.1(C) and 46:460.33(B).

HISTORICAL NOTE: Promulgated by the Department of Health, Board of Pharmacy, LR 44:

§1130. Louisiana Uniform Prescription Drug Prior Authorization Form

LOUISIANA UNIFORM PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

SECTION I - SUBMISSION

Submitted to:	Phone:	Fax:	Date:
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SECTION II - PRESCRIBER INFORMATION

Last Name, First Name MI:		NPI# or Plan Provider #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION III - PATIENT INFORMATION

Last Name, First Name MI:		DOB:	Phone:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
				<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
Address:		City:	State:	ZIP Code:	
Plan Name (if different from Section I):	Member or Medicaid ID #:	Plan Provider ID:			
Patient is currently a hospital inpatient getting ready for discharge? ___ Yes ___ No		Date of Discharge: _____			
Patient is being discharged from a psychiatric facility? ___ Yes ___ No		Date of Discharge: _____			
Patient is being discharged from a residential substance use facility? ___ Yes ___ No		Date of Discharge: _____			
Patient is a long-term care resident? ___ Yes ___ No		If yes, name and phone number: _____			
EPSDT Support Coordinator contact information, if applicable: _____					

SECTION IV - PRESCRIPTION DRUG INFORMATION

Requested Drug Name:						
Strength:	Dosage Form:	Route of Admin:	Quantity:	Days' Supply:	Dosage Interval/Directions for Use:	Expected Therapy Duration/Start Date:
To the best of your knowledge this medication is: ___ New therapy/Initial request ___ Continuation of therapy/Reauthorization request						
For Provider Administered Drugs only:						
HCPCS/CPT-4 Code: _____		NDC#: _____		Dose Per Administration: _____		
Other Codes: _____						
Will patient receive the drug in the physician's office? ___ Yes ___ No						
- If no, list name and NPI of servicing provider/facility: _____						

SECTION V - PATIENT CLINICAL INFORMATION

Primary diagnosis relevant to this request:	ICD-10 Diagnosis Code:	Date Diagnosed:
Secondary diagnosis relevant to this request:	ICD-10 Diagnosis Code:	Date Diagnosed:
For pain-related diagnoses, pain is: _____ Acute _____ Chronic		
For postoperative pain-related diagnoses: Date of Surgery _____		
Pertinent laboratory values and dates (attach or list below):		
Date	Name of Test	Value

SECTION VI - THIS SECTION FOR OPIOID MEDICATIONS ONLY

Does the quantity requested exceed the max quantity limit allowed? ___Yes ___No (If yes, provide justification below.)
 Cumulative daily MME _____

Does cumulative daily MME exceed the daily max MME allowed? ___Yes ___No (If yes, provide justification below.)

	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
	SHORT AND LONG-ACTING OPIOIDS		
			N The patient has been screened for substance abuse / opioid dependence. (Not required for recipients in long-term care facility.)
			C The PMP will be accessed each time a controlled prescription is written for this patient.
			P A treatment plan which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			C Criteria for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			R Benefits and potential harms of opioid use have been discussed with this patient.
LONG-ACTING OPIOIDS			S An Opioid Treatment Agreement signed by both the patient and prescriber is on file. (Not required for recipients in long-term care facility.)
			T The patient requires continuous around the clock analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			U Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in pharmacologic/non-pharmacologic treatment section below.
			V Medication has not been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			W Medication has not been prescribed for use as an as-needed (PRN) analgesic.
		X Prescribing information for requested product has been thoroughly reviewed by prescriber.	

IF NO FOR ANY OF THE ABOVE (A-L), PLEASE EXPLAIN:

**SECTION VII - PHARMACOLOGIC & NON-PHARMACOLOGIC TREATMENT(S) USED FOR THIS DIAGNOSIS
(BOTH PREVIOUS & CURRENT):**

Drug name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason
Drug Allergies:			Height (if applicable):	Weight (if applicable):
Is there clinical evidence or patient history that suggests the use of the plan's pre-requisite medication(s), e.g. step medications, will be ineffective or cause an adverse reaction to the patient? ___Yes ___No (If yes, please explain in Section VIII below.)				

SECTION VIII - JUSTIFICATION (SEE INSTRUCTIONS)

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Signature of Prescriber: _____

Date: _____

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1006.1(C) and 46:460.33(B).

HISTORICAL NOTE: Promulgated by the Department of Health, Board of Pharmacy, LR 44:

Family Impact Statement

In accordance with Section 953 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a family impact statement on the Rule proposed for adoption, repeal, or amendment. The following statements will be published in the Louisiana Register with the proposed agency Rule.

1. The effect on the stability of the family. The proposed Rule will have no effect on the stability of the family.
2. The effect on the authority and rights of parents regarding the education and supervision of their children. The proposed Rule will have no effect on the authority and rights of parents regarding the education and supervision of their children.
3. The effect on the functioning of the family. The proposed Rule will have no effect on the functioning of the family.
4. The effect on family earnings and family budget. The proposed Rule will have no effect on family earnings or family budget.
5. The effect on the behavior and personal responsibility of children. The proposed Rule will have no effect on the behavior and personal responsibility of children.
6. The ability of the family or a local government to perform the function as contained in the proposed Rule. The

proposed Rule will have no effect on the ability of the family or a local government to perform the activity as contained in the proposed Rule.

Poverty Impact Statement

In accordance with Section 973 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a poverty impact statement on the Rule proposed for adoption, repeal, or amendment.

1. The effect on household income, assets, and financial security. The proposed Rule will have no effect on household income, assets, or financial security.
2. The effect on early childhood development and preschool through postsecondary education development. The proposed Rule will have no effect on early childhood development or preschool through postsecondary education development.
3. The effect on employment and workforce development. The proposed Rule will have no effect on employment or workforce development.
4. The effect on taxes and tax credits. The proposed Rule will have no effect on taxes or tax credits.
5. The effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance. The proposed Rule will have no effect on child and dependent care, housing, nutrition, transportation, or utilities assistance. To the extent the child requires a prescription drug for which the insurer requires a prior authorization process, the use of a single prescription drug prior authorization form by all parties in the state could simplify that process and improve access to the medication, with a positive impact on health care.

Provider Impact Statement

In accordance with House Concurrent Resolution No. 170 of the Regular Session of the 2014 Legislature, there is hereby submitted a provider impact statement on the Rule proposed for adoption, repeal, or amendment. This will certify the agency has considered, without limitation, the following effects on the providers of services to individuals with developmental disabilities:

1. The effect on the staffing level requirements or qualifications required to provide the same level of service. The proposed Rule will have no effect on the staffing level requirements or the qualifications for that staff to provide the same level of service.

2. The total direct and indirect effect on the cost to the provider to provide the same level of service. To the extent a provider includes the prescribing or dispensing of prescription medications to their clients, and to the extent that provider has previously established a prescription drug prior authorization process (or some multiple thereof) which is substantially different from the proposed form or its electronic equivalent, the provider may incur a one-time cost to revised its existing process to conform to the proposed process. However, we anticipate savings will accrue from the use of a single form by all parties in the state.

3. The overall effect on the ability of the provider to provide the same level of service. The proposed Rule will have no effect on the ability of the provider to provide the same level of service.

Regulatory Flexibility Analysis

In accordance with Section 965 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a regulatory flexibility analysis on the Rule proposed for adoption, repeal, or amendment. This will certify the agency has considered, without limitation, each of the following methods of reducing the impact of the proposed Rule on small businesses:

1. The establishment of less stringent compliance or reporting requirements for small businesses. There are no specific reporting requirements in the proposed Rule.

2. The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses. There are no specific reporting requirements in the proposed Rule.

3. The consolidation or simplification of compliance or reporting requirements for small businesses. There are no specific reporting requirements in the proposed Rule.

4. The establishment of performance standards for small businesses to replace design or operational standards required in the proposed Rule. The proposed Rule requires the use of a single form by all parties in the state, which could eliminate the need to maintain multiple forms for different third-party payors. In addition, the proposed Rule permits the use of electronic equivalents to the written form.

5. The exemption of small businesses from all or any part of the requirements contained in the proposed Rule. There are no exemptions for small businesses.

Public Comments

Interested persons may submit written comments, via United States Postal Service or other mail carrier, or in the alternative, by personal delivery, to Malcolm J Broussard,

Executive Director, at the office of the Louisiana Board of Pharmacy, 3388 Brentwood Drive, Baton Rouge, LA 70809-1700. He is responsible for responding to inquiries regarding this proposed Rule.

Public Hearing

A public hearing on this proposed Rule is scheduled for 9 am on Friday, September 28, 2018 at the office of the Louisiana State Board of Medical Examiners, which is located at 630 Camp Street in New Orleans, LA 70130. At that time, all interested persons will be afforded an opportunity to submit data, views, or arguments, either orally or in writing. The deadline for the receipt of all comments is 12 noon that same day.

Malcolm J Broussard
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Uniform Prescription Drug Prior Authorization Form

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The LA Board of Pharmacy anticipates one-time printing expenditures of \$2,000 in FY 19 to publish the Notice of Intent and the final rule publication. The proposed rules implement Act 423 of the 2018 Regular Session regarding the use of a single prior authorization form for prescription drugs.

Furthermore, to the extent local governmental units utilize prior authorization forms, there may be a nominal cost to change their existing form to comply with the uniform document in the proposed rules. To the extent governmental units use multiple prior authorization forms for different payors, there may be future cost savings associated with the use of a single form, however any potential savings from this source is speculative.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rules will not affect revenue collections for state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rules may benefit insurance companies and other entities that pay for prescription drug claims, as they may require the use of a prior authorization process for some drugs to manage their costs for such claims. Different entities may use different forms and some entities have initiated the use of electronic web portals to receive the information in lieu of printed forms. The proposed rules provide for a single form for use by all payors in the state, which may streamline the prior authorization process for payors.

Furthermore, some entities will incur printing costs for printing replacement forms. Furthermore, to the extent any of those providers have implemented information systems for the prior authorization process, they may incur a one-time expense to update their system to accommodate the uniform process proposed by the rule.

In addition, the prescribers and dispensers of prescription drugs required to complete the prior authorization process may benefit from the use of a single form for all payors in the state, as it may streamline the prior authorization process to the extent multiple forms are currently being used.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)

The proposed rules will not affect competition or employment.

Malcolm Broussard
Executive Director
1808#036

Evan Brasseaux
Staff Director
Legislative Fiscal Office



Louisiana Board of Pharmacy

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Summary of Testimony & Public Comments
re
Regulatory Project 2018-2 ~ Louisiana Uniform Prescription Drug Prior Authorization Form
at
September 28, 2018 Public Hearing

1. September 25, 2018 letter from Elisa Y. Muller, on behalf of Quarles & Brady

Requested no revisions to the rule or the form, but posed two questions:

- Whether health insurance issuer is permitted to use its own prior authorization form as long as it conforms to the regulatory requirements; and
- Whether health insurance issuer is permitted to include other fields for physicians to complete when submitting the prior authorization form.

2. September 28, 2018 letter from Kim Diehl-Boyd, on behalf of CoverMyMeds

Posed three questions, then offered two comments and six recommendations:

- Whether a prescriber, pharmacy, or payor already utilizing electronic prior authorizations (ePA) would be required to modify their process and use the promulgated form;
- Whether a health plan could require the prescriber or pharmacy to start a new PA process if the prescriber or pharmacy had already initiated the promulgated form with respect to a specialty medication;
- Whether a health plan could require the prescriber or pharmacy to start a new PA process if the prescriber or pharmacy had already initiated the promulgated form with respect to a medication ordered with an electronic prescription;
- Suggested the provider-administered section of the form would not be necessary since the form is not to be used for specialty medications;
- Suggested the inclusion of guidance to the prescriber or pharmacy that the form was not necessary for a specialty medication or if the medication was prescribed electronically;
- Recommended an expansion of the tried and failed section to include more drug history information;
- Recommended a separate section for non-pharmacologic therapies;
- Recommended adding a section for additional clinical criteria;
- Recommended adding a field for the prescriber to indicate urgent or non-urgent requests;
- Recommended additional space for date of diagnosis, ICD-10 codes and description of diagnosis;
- Recommended adding an instructional note to the prescriber to attach any relevant documentation to facilitate the decision-making process.

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PUBLIC HEARING
FRIDAY, SEPTEMBER 28, 2018
THE LOUISIANA STATE
BOARD OF MEDICAL EXAMINERS
630 CAMP STREET
NEW ORLEANS, LOUISIANA 70130

A Public Hearing was held at the
 Louisiana State Board of Medical Examiners
 Office commencing at 9:01 a.m.

PANEL MEMBERS:

- James A. Taylor, Jr., MD
- Terrie R. Thomas, MD
- Christy L. Valentine, MD
- Daniel K. Winstead, MD
- Roderick V. Clark, MD
- Kweli J. Amusa, MD

Vincent A. Culotta, Jr., MD
 LSBME Executive Director

MODERATOR:

Philip Bergeron, Esq.

ALSO PRESENT:

Malcolm Broussard, R.Ph,
 Executive Director
 Louisiana Board of Pharmacy

REPORTED BY: Shelley A. Sampey, CCR
 Certified Court Reporter
 State of Louisiana, #93011

P R O C E E D I N G S

1
2 DR. VALENTINE:

3 Good morning everyone. I am
4 Dr. Christy Valentine. I'm the
5 Louisiana State Board of Medical
6 Examiners president. And I have asked
7 Mr. Phil Bergeron to moderate today's
8 hearing. He's going to ensure that
9 everyone that would like an
10 opportunity to speak has that
11 opportunity.

12 So thank you, Phil, this
13 morning.

14 MR. BERGERON:

15 Thank you, Dr. Valentine.
16 Ladies and gentlemen, welcome. This
17 meeting is being called, it's a joint
18 meeting by the Louisiana State Board
19 of Medical Examiners and the Louisiana
20 State Board of Pharmacy. I should say
21 a joint hearing. And they're
22 convening to receive public comments,
23 information, views, data and arguments
24 from all interested persons and
25 organizations on some proposed rules

1 governing the Uniform Prescription
2 Drug Prior Authorization Form. This
3 form is mandated by Act 423 of the
4 2018 regular session of the
5 legislature.

6 Mr. Malcolm Broussard, who is
7 the executive director of the
8 Louisiana State Board of Pharmacy is
9 here as well. He's graciously allowed
10 me to make these opening comments. He
11 may have something to say after I
12 conclude the opening comments. But he
13 is here on behalf of the Pharmacy
14 Board to receive comments as well.

15 There are several members of the
16 Board present here today. From my
17 left, your right, we have Dr. Kweli
18 Amusa, Dr. Rod Clark, Dr. Daniel
19 Winstead, Dr. Terrie Thomas and
20 Dr. James Taylor. Of course, our
21 president has introduced herself,
22 Dr. Christy Valentine.

23 A few housekeeping issues
24 quickly. Two emergency exits on this
25 floor, one on my right to your left

1 next to the elevator, one on my left
2 at the far end of the hall. There are
3 restrooms at the far end of the hall
4 as well. If you would, please mute
5 your phones and avoid talking to
6 anyone in the audience while the
7 speakers are talking.

8 We don't have a very big
9 audience today, so a lot of the
10 formalities will be skipped over.
11 Notice of Intent for these rules was
12 published in the Louisiana Register in
13 accordance with the Louisiana
14 Administrative Procedure Act. They
15 were electronically filed on both the
16 Board's web page of the LSBME and the
17 Pharmacy Board noticing the intent and
18 the proposed rules and of this hearing
19 that is being held this morning at
20 9 o'clock. Let Ms. Reporter please
21 note that the hearing started about
22 three minutes ago. It's five after 9
23 now.

24 Copies of the proposed rules are
25 available from Ms. Arceneaux. These

1 are the rules that were published in
2 the August 2018 edition of the
3 Louisiana Register, Volume 44,
4 Number 08. Copies are available, as
5 I've said. These records, these
6 documents, will be made part and
7 parcel of this rule-making effort, as
8 will all of the written comments
9 received during the comment period.

10 I will note for the audience and
11 the folks present here that the
12 comment period concludes at noon
13 today. So if someone has written
14 comments they would like to offer
15 following this hearing, they can offer
16 them in writing, electronically or
17 hard copy to Ms. Arceneaux or to
18 Mr. Broussard by noon today.

19 The proceedings are being
20 recorded by a recorder, by a
21 stenographer, and will be made
22 available to the members of the Boards
23 for their review in the rule-making
24 process.

25 Just a few procedural rules

1 before we hear the comments. First of
2 all, if you wish to offer a comment,
3 please obtain a speaker request card
4 from Ms. Arceneaux identifying the
5 name of the organization and the
6 capacity in which you are appearing
7 today so that we will have that
8 information available. Also, please
9 sign the attendee register so we will
10 know who is present and wishing to
11 speak. And, finally, because these
12 are joint rules that have been noticed
13 for intent, please specify whether
14 your comments are directed to the
15 Pharmacy Board, the Medical Board or
16 both. The attendance register and the
17 speaker cards, of course, are
18 necessary for the Board to fulfill its
19 obligations under the law, both to
20 report to the legislature on the
21 comments received and to respond to
22 you with respect to the Board's answer
23 to your comments.

24 We have a microphone here and a
25 chair in the front of the room.

1 Anyone wishing to speak, I would ask
2 that you come up to the microphone,
3 make sure it's on, state your name,
4 the organization that you're
5 representing and the capacity, and
6 then proceed to give your comments.
7 Keep in mind that today's meeting is
8 to receive public comments, not to
9 respond to them. So while the Board
10 may ask you questions, it's not a
11 hearing capacity to respond to those
12 questions. That, of course, will be
13 handled when the Board issues written
14 responses to all the comments that
15 have been offered.

16 I believe, Madam President, we
17 have reserved an hour for this
18 morning's hearing?

19 **DR. VALENTINE:**

20 Yes, we have.

21 **MR. BERGERON:**

22 So, again, after that time
23 frame, written comments can still be
24 received if directed to either
25 Ms. Arceneaux with the Board of

1 Medical Examiners or Mr. Broussard
2 here on behalf of the Board of
3 Pharmacy.

4 Mr. Broussard, do you have
5 anything that I've omitted that you
6 would like to add?

7 **MR. BROUSSARD:**

8 Good morning, Madam President
9 and members. We appreciate the
10 Board's invitation to collaborate with
11 this public hearing on a rule that we
12 are jointly promulgating.

13 Mr. Bergeron did an excellent job in
14 summarizing the proceedings.

15 The only thing we would add is
16 we would like to put into the record
17 that we have received two written
18 correspondences prior to the beginning
19 of today's hearing. And to identify
20 those for us, the first is a letter
21 from the firm Coils & Braden (assumed
22 spelling) in Chicago, and it was
23 received in our office at the Board of
24 Pharmacy in Baton Rouge yesterday on
25 the 27th, and it is primarily

1 questions and not comments. And today
2 we received a letter from CoverMyMeds,
3 and we understand that person is in
4 the audience. They may choose to
5 supplement their written comments, and
6 we appreciate these are questions as
7 well as comments. So those are the
8 two written documents we have received
9 prior to today's hearing.

10 Thank you, and we'll be here to
11 participate in the hearing till the
12 very end. Thank you very much.

13 **MR. BERGERON:**

14 Thank you.

15 **DR. CULOTTA:**

16 Mr. moderator, Madam President,
17 and Board Members, we also received a
18 letter from CoverMyMeds as well, and
19 we have got copies for everybody, and
20 we'll get them to you right now.

21 **MR. BERGERON:**

22 Thank you, Mr. Broussard,
23 Dr. Culotta.

24 With those comments, we do have
25 one speaker request card that has been

1 completed by Ms. Kim Boyd. Ms. Boyd,
2 thank you for joining the Boards this
3 morning. If you have anything to add
4 to the communication that both Boards
5 received this morning, please feel
6 free to come up to the speaker table,
7 identify your organization and
8 capacity and proceed to give us your
9 comments.

10 MS. BOYD:

11 I think I'm the only one in the
12 room. I'm not used to that.

13 Thank you, Madam President,
14 members of the Board, directors,
15 associate directors. My name is Kim
16 Boyd. I am director of industry
17 relations and government affairs at
18 CoverMyMeds. I've been on board at
19 CoverMyMeds for about three years now,
20 but been in the health care space
21 probably, well, about 20 years now.
22 I'm not as experienced as I'm sure
23 many of you here are. I definitely am
24 not a doctor. But I do appreciate
25 your time today. This is a very

1 important piece of regulation to the
2 health care industry, more
3 specifically to the medication PA
4 process.

5 By way of background -- and you
6 have the letter here, so I'm not going
7 to regurgitate everything that's in
8 the letter. But there are some points
9 I would like to make that, you know,
10 by way of background, CoverMyMeds is a
11 health care IT company. We were
12 formed in 2008. We're out of
13 Columbus, Ohio. I'm from Nashville,
14 if you can't hear the accent. But
15 I've been on board with them about
16 three years now.

17 In 2008, they formed to help
18 expedite or improve the medication PA
19 process. Our founder who is -- I
20 think he's 38, and highly intelligent,
21 more intelligent than I care to think
22 I would ever be, was approached by a
23 really good friend of his who is a
24 doctor and said: I have a real
25 problem. I have patients who need

1 their medication and it's taking me
2 days, if not weeks, because of the
3 laborious PA process to get the
4 patient the medication. Matt, I know
5 you're a really smart guy, you're a
6 technical guy. What can you do to
7 help me?

8 So therein formed CoverMyMeds.
9 Basically, the doctor said: I can't
10 get my patients' meds covered. So
11 that's where the name came from. So
12 what we started to do in 2008 is to
13 build this library of all of the prior
14 authorization forms that were in the
15 industry. So as a way for the
16 physician to quickly find those forms
17 instead of having to search each
18 state's website or each directory, go
19 to one location, go to a portal.
20 Today we still house roughly 14,000
21 forms in that portal. We do process
22 PAs nationwide, so that's why there is
23 this huge library of forms. About
24 9,000 of them are still currently in
25 play, a lot of them associated more so

1 with Medicaid, but there are many on
2 the commercial side and many -- you
3 know, there's Medicare as well. So we
4 cover all plans, all medications
5 through the CoverMyMeds process.

6 But what we started to do
7 shortly thereafter, there was a
8 standard that was named by the
9 National Council for Prescription Drug
10 Programs, or NCPDP. They are the
11 standards development organization
12 that standardizes everything for the
13 pharmacy community. They have been an
14 organization for about 40 years now.
15 They have roughly 26 standards on
16 their books. Each day task groups
17 work to evolve those standards as the
18 industry evolves.

19 So about 10 years ago the NCPDP
20 script standard was adopted, was
21 created. That standard houses the
22 e-Prescribing standard as well as the
23 ePA transactions that are present
24 today and utilized today. So we went
25 from a very, you know, paper-driven

1 process -- and the PA process for
2 paper takes about three to five days
3 to get completed. So the patient gets
4 their prescription from the pharmacy,
5 whether it's -- excuse me, not from
6 the pharmacy, from the provider.
7 Whether it's e-Prescribed to the
8 pharmacy or it is written by hand, the
9 ePA process can still take place and
10 it does today. So that standard
11 allows for that. It is a four-part
12 transaction that is done computer to
13 computer that allows the prescriber to
14 quickly identify the patient, the
15 need, the medication, and it's done in
16 real time versus the paper process
17 which takes three to five days. The
18 ePA process takes about one day for
19 the patient to get a determination
20 from the plan, sometimes 10 minutes.
21 It really just depends on the plan and
22 their integration at this point.

23 Today CoverMyMeds does a little
24 over two million prior authorizations
25 a month. We've helped over one

1 hundred million patients get the
2 medications they need to live healthy
3 lives. So while we are not completely
4 adverse to the adoption of a Uniform
5 Prescription Form, and we understand
6 that SB29 is calling for the two
7 Boards to come together and create
8 this form, we definitely have some
9 questions and we also wanted to make
10 sure that the Boards were well aware
11 that the State of Louisiana is well
12 down the pathway of adopting the ePA.

13 Through CoverMyMeds right now,
14 we cover about 75 percent of those PAs
15 that come to us are done
16 electronically today versus via the
17 paper form. So we want to ensure as
18 the Boards consider this rule-making
19 that there is some clarification that
20 is put in the rules. Because I know
21 the SB29 indicated that this form
22 would not need to be utilized if
23 e-Prescribing was done or if it was a
24 specialty medication. So what, again,
25 we would like the Board to help us

1 understand is that if a payer and a
2 provider and/or a pharmacy are
3 completing the PA process today
4 electronically that they would not
5 need to revert to this form and begin
6 using this form versus using the ePA
7 process. Patients know pretty much
8 that day whether or not their
9 medications are covered and can pick
10 it up at the pharmacy versus having to
11 leave the pharmacy without a
12 medication in hand waiting for the
13 paper form to get completed. So,
14 again, that is one thing that I would
15 like clarification from the Board on
16 is to make sure that the ePA process
17 will not be deterred or be overwritten
18 by this form that is adopted by the
19 two Boards.

20 Secondly, I also want to make
21 sure that should a prescriber pick out
22 this uniform form and it happens to be
23 a prescription that was electronically
24 prescribed that the plans do not say,
25 oh, it was electronically prescribed,

1 you don't have to use this form, use
2 another form, that the plan will
3 continue with the PA process through
4 the Uniform Prescription Drug Form and
5 continue to move that process
6 downstream. We have seen instances
7 where the incorrect form was pulled
8 and/or used and a plan has denied the
9 PA, saying, you've used the wrong
10 form. So that's really what I'm
11 trying to get at is to make sure that
12 even if the prescriber pulls this form
13 and uses it for a e-Prescribed
14 medication or for a specialty
15 medication that the process will
16 continue and the patient will not have
17 to wait or the prescriber will not
18 have to start over. That does not
19 bode well for patient access. And I
20 think at the end of the day we're
21 trying to get the patients what they
22 need to live healthy lives.

23 So those were really the three
24 questions or clarifications that we
25 would seek from the Board on this.

1 There are a couple of comments that
2 are -- we called the PDA content team.
3 They're the ones who manage all of
4 those forms, and they've seen the
5 14,000 forms a lot. So I asked that
6 team for their comments about the
7 current proposed form and what is on
8 it, and they gave me a few comments to
9 provide to you for clarification as
10 well, and they are included in the
11 letter that I'm submitting.

12 But one of the comments that is
13 there that I would like to highlight
14 that is: The provider -- excuse me, I
15 have a cold, I'm so sorry -- the
16 provider-administered drugs section
17 would not be necessary on the current
18 proposed form since the utilization of
19 this section is usually for specialty
20 medications only. And if this form is
21 not to be used for specialty
22 medications, there should really not
23 be an area for that. Secondly, since
24 this form is not necessary for use if
25 it is a specialty medication or the

1 prescription was e-Prescribed, we
2 suggest placing a message or a
3 notation somewhere on the form letting
4 the physician know that this form will
5 not be utilized in those two
6 instances, just to give them
7 clarification.

8 Some other recommendations they
9 had was to expand the tried and failed
10 section on the form to accommodate for
11 additional drug history to make sure
12 that all necessary drug history could
13 be completed on the form.

14 Also, to create a separate
15 action for non-pharmacologic
16 therapies, to also add a section or a
17 question or expansion of the clinical
18 criteria section. I'm sure most of
19 you, as physicians, understand that
20 providing the clinical efficacy
21 information is usually paramount to
22 getting a determination made for a
23 medication PA. It's one of the most
24 critical pieces of the PA process.

25 Also, to add a field for a

1 provider to indicate the urgency of
2 this request. There are many times
3 that a patient has an urgent need for
4 the medication that is being
5 requested. And usually a plan, when
6 they are given that information, will
7 put it through an expedited process as
8 required by law.

9 Also, to add -- excuse me -- a
10 date of diagnosis ICD-10 area. And
11 the diagnosis description area should
12 also be given additional information.
13 There are many times that you --
14 you obviously probably know this --
15 you have a primary diagnosis, but you
16 also have secondary symptoms, and so
17 there are medications that could
18 potentially be prescribed for
19 off-label use from a diagnosis. And
20 being able to identify those reasons
21 in that area, we think, would be
22 beneficial.

23 Also, and last but not least,
24 consider adding a note instructing the
25 provider to attach any appropriate or

1 applicable documentation so the plan
2 doesn't have to come back and ask for
3 that information, again delaying the
4 PA process.

5 And that is all for me. Thank
6 you so much. And, of course, I'm
7 happy to answer any questions the
8 Board may have. But if not, I really
9 appreciate your time today.

10 MR. BERGERON:

11 Just a clarification. The
12 comments that you have are directed to
13 both Boards?

14 MS. BOYD:

15 That's correct, sir.

16 MR. BERGERON:

17 And aside from what is on -- I
18 think you've outlined your comments on
19 the form today. Is there anything
20 else that you would like to add? I
21 mean, your comments kind of duplicated
22 what is on the written form -- written
23 communication.

24 THE WITNESS:

25 Right. Yes, sir.

1 MR. BERGERON:

2 Okay. I just wanted -- Do any
3 of the Board members have any
4 questions this morning?

5 DR. TAYLOR:

6 Thank you for coming today. I'm
7 actually doing the real time testing
8 to some of my gynos and colleagues,
9 and they seem to like your process
10 better than the old process, frankly.

11 MS. BOYD:

12 Thank you.

13 DR. TAYLOR:

14 And I was looking over your
15 recommendations before the meeting.
16 Actually, some of these, I believe,
17 make a good deal of sense. I did want
18 to drill down one question, though.
19 Provider-administered drugs section
20 wouldn't be necessary. In your
21 experience, are there any
22 physician-administrated drugs that are
23 not also designated as specialty
24 drugs? In other words, would there be
25 a situation -- and, again, I'm

1 thinking of a matter like for a
2 vaccination that as a pharmacy benefit
3 they would have to get that covered or
4 something like whether that be as an
5 every-six-month osteoporosis
6 injection. Are there any medications
7 that you're aware of that would fall
8 outside the specialty drug that would
9 be given in the physician's office or
10 that patient could actually
11 self-administer and not choose to
12 administer in a physician's office?

13 MS. BOYD:

14 Great question. I can't think
15 of any -- anyone. I did ask the
16 group, you know, in the content team,
17 and we have six clinical pharmacists
18 who are on staff there. I know the
19 two they reviewed, and that those were
20 their comments. So I can go back and
21 ask more specifically, and I'm happy
22 to do that for the Board.

23 DR. TAYLOR:

24 Again, it's an unusual event,
25 but I wouldn't say that it's

1 nonexistent, at least in my practice.
2 And also back up for -- and to get a
3 better idea, because I actually get
4 CoverMyMeds' faxes -- or responses at
5 my office as well. How do you get --
6 you as a company -- get involved in
7 the process? Because sometimes I'll
8 get a patient, and I'll see the form
9 with the code numbers on it, and
10 sometimes I don't. Are you contracted
11 to the insurance companies? Are you
12 contracted to the pharmacy medical
13 manager? How does CoverMyMeds come
14 into the process, and what's your
15 relationship on the front and back end
16 of that process?

17 MS. BOYD:

18 Sure. So the CoverMyMeds
19 process, we do not charge providers
20 nor pharmacies to utilize our process.
21 We are connected with all pharmacies.
22 A hundred percent of pharmacies are
23 connected through ePA. Providers can
24 utilize -- they can log in
25 individually and use our portal and

1 still do ePA through a portal or we
2 are connected directly with their
3 EHRs. So we have those -- those are
4 how we connect with those two pieces
5 of the puzzle. It is the plans who
6 compensate CoverMyMeds for the
7 transaction process.

8 DR. TAYLOR:

9 And I don't know if you haven't
10 answered this question, but would it
11 be your experience that a majority of
12 those interactions actually start from
13 the pharmacy?

14 MS. BOYD:

15 Correct. Roughly -- it used to
16 be a little bit higher, but presently
17 about 65 to 69 percent on any given
18 state. The pharmacy is the one who
19 initiates the PA. So the prescriber
20 will prescribe either paper
21 e-Prescribing, you go to pick up your
22 prescription and it says, sorry, it's
23 been rejected because it needs a PA.
24 So the pharmacy will -- we have what
25 is called an easy button inside the

1 majority of the 65,000 pharmacies
2 nationwide, and they just touch that
3 button and it automatically creates
4 the start of the PA. So it does the
5 demographic information, it puts in
6 the patient medication information,
7 and it sends it off to the provider to
8 the plan. And the plan will then send
9 the clinical criteria question set
10 which is unique to the patient and the
11 medication. That is the difference
12 between a form and the ePA process as
13 well. A form has general questions on
14 it. Most of the time the plan comes
15 back and asks the prescriber more
16 questions that are specific to you or
17 me and our medication. So the
18 pharmacy will start it off due to that
19 rejection, and then the provider and
20 the plan will then take up the process
21 electronically. Again, the clinical
22 questions that are asked that is
23 unique to you or I and the medication
24 and the doctor's system either pulls
25 the information and answers it or

1 someone within the physician's office
2 will answer those few questions and
3 send it back to the plan
4 electronically.

5 In the ePA process, just to dig
6 a little deeper, auto determinations
7 are done. People are not picking up a
8 piece of paper or a book and going
9 through this flow chart of questions
10 and seeing what was answered "yes,"
11 "no," that sort of thing. The systems
12 are doing that. That's why ePA is so
13 much faster, because the auto
14 determination happens through ePA.

15 Does that answer your question?

16 DR. TAYLOR:

17 Yes. Thank you.

18 MS. BOYD:

19 Perfect. Thank you.

20 MR. BERGERON:

21 I'm looking -- just out of
22 curiosity, I'm looking through your
23 suggestions on Page 2 of your
24 communication.

25 THE WITNESS:

1 Yes, sir.

2 MR. BERGERON:

3 And so your first one is to the
4 provider-administered drugs section
5 wouldn't be necessary since this form
6 is not to be utilized for specialty
7 medications. And then again, since
8 this form is not necessary for use if
9 the prescription for the medication or
10 the prescription, if it was e-filed,
11 we suggest placing a message at the
12 top. Could not that be accomplished
13 simply by the -- by "N/A," by use of
14 the not applicable, not applicable to
15 this drug?

16 MS. BOYD:

17 I'm so sorry. Could you repeat
18 that question?

19 MR. BERGERON:

20 Could the present form not be
21 utilized simply with the notation "not
22 applicable, specialty drug."

23 MS. BOYD:

24 Correct. Correct. And I think
25 that's the recommendation we're making

1 here, if we could put someplace on the
2 form that specialty medication, not
3 applicable, e-Prescribed, not
4 applicable. So when the physician
5 pulls up -- so, for example, in our
6 portal where we house all of these
7 forms, the prescriber will go in and
8 pick the appropriate form or format to
9 begin that process if they go through
10 the portal process. We want to make
11 sure that they pick the right one. So
12 if it's -- the question's still going
13 to come into play -- the question
14 still comes into play as who defines
15 specialty as well. I did not put that
16 in my comments here, but who defines
17 what's a specialty drug.

18 You could have a prescriber
19 thinking they're doing a specialty
20 drug for Blue Cross Blue Shield, they
21 send it over, Blue Cross Blue Shield
22 says, no, we consider that a specialty
23 drug. So the definition of specialty
24 still comes into play as well.

25 There's no universal definition of

1 specialty in our -- we've got CMS who
2 has a definition. But there's no real
3 true universal definition that's been
4 defined yet of what a specialty drug
5 is. So I think if we could get some
6 clarification so they know which form
7 to pick and where to go so it doesn't
8 delay the process...

9 MR. BERGERON:

10 Next question: Expand the tried
11 and failed section to accommodate more
12 drug history. What specific section
13 are you referring to?

14 MS. BOYD:

15 I'm sorry, sir. I don't have
16 the form in front of me. I might have
17 it in front of me here.

18 MR. BERGERON:

19 It's in the rule. Do you have a
20 copy?

21 MS. BOYD:

22 It was in the rule. I do not
23 now. Do you have one, Rita?

24 MR. BERGERON:

25 Ms. Arceneaux, could you get a

1 copy? I just want to make sure that
2 we understand exactly the section that
3 you're referring to.

4 MS. BOYD:

5 And my apologies for not
6 notating the section specifically.
7 Let me see if I can find it. Sir,
8 where it says continue -- so under
9 Section IV: Prescription drug
10 information, where it says: To the
11 best of your knowledge this medication
12 is for a new therapy or a continuation
13 of therapy or a reauthorization part,
14 that is what our team would call a
15 tried and fail. Is it a
16 reauthorization, is it something that
17 you were taking before, and put
18 information in there. Because we do
19 get a lot of questions. We do
20 basically step therapy. So PA in the
21 system could be, you know, a step
22 therapy request, an exception to an
23 off label, quantity limit, things of
24 that nature. So there could be some
25 additional section here that a

1 prescriber can indicate that a former
2 medication that might be on a
3 formulated benefit that would not
4 require PA has been tried and failed.

5 Does that make sense?

6 **MR. BERGERON:**

7 Clarification also: Create a
8 separate section for non-pharmacologic
9 therapies. Section VII currently
10 applies to both pharmacologic and
11 non-pharmacologic treatments. Is that
12 -- is it your view that that needs to
13 be supplemented or changed?

14 **MS. BOYD:**

15 Let me go back. The
16 recommendation was to actually split
17 those out and make those two separate
18 sections so you have pharmacologic and
19 non-pharmacologic. The recommendation
20 would be to split those two out just
21 for clarity.

22 **MR. BERGERON:**

23 A field to indicate the urgency
24 of the request, I think is --

25 **MS. BOYD:**

1 Yes, sir. On many forms you'll
2 have at the top, Urgent/Nonurgent, a
3 box that could be checked. On many
4 other standard forms there's a place
5 to designate that. Usually it is a
6 check box or a line that could be
7 checked.

8 **MR. BERGERON:**

9 I think I just wanted to make
10 sure the Board had clarification on
11 those issues. Thank you so much.

12 **MS. BOYD:**

13 Thank you. I appreciate it.

14 **DR. VALENTINE:**

15 Yes, Mr. Broussard?

16 **MR. BROUSSARD:**

17 Madam President, if I may, I
18 think my members would appreciate if I
19 would ask Ms. Boyd some questions.

20 **DR. VALENTINE:**

21 Absolutely.

22 **MR. BROUSSARD:**

23 I'll pick up this last one first
24 asking for a separate section for the
25 non-pharmacologic therapies. Knowing

1 that the existing law that legislation
2 addressed at 423, existing law limits
3 the size of the form to two pages, if
4 you wanted to create another section
5 to expand, are you willing to collapse
6 something else so that it could fit,
7 that would make it all fit. I think
8 the drafters of the form are trying to
9 fit as much as they could into the
10 two-page limitation.

11 **MS. BOYD:**

12 Absolutely. I'm wondering on
13 the non-pharmacologic area -- and I
14 can never say that right, so my
15 apologies -- if only a couple of lines
16 would be sufficient. It looks like it
17 if you look at -- so right now, would
18 this be a three-page directive? Would
19 this be a three-page that we're
20 looking at right now?

21 **MR. BROUSSARD:**

22 What we're looking at now is a
23 two-page form.

24 **MS. BOYD:**

25 Okay. There is a little wiggle

1 room. I would suggest maybe if you
2 can expand that out maybe giving it
3 only a couple of sections or a couple
4 of lines if you could do that. I'm
5 not sure -- they did not indicate when
6 we -- I reviewed it and they reviewed
7 it. We didn't see anything that
8 should be necessarily taken out of
9 here. There was coverage that was
10 applicable to many other forms, so we
11 didn't see any area to really remove.

12 MR. BROUSSARD:

13 And so the same question applies
14 to all the other items that you wish
15 to add. It becomes a matter of,
16 logistically, how would the form
17 creators manage all the data fields
18 within the two-page limit when the
19 Boards do not have the option of
20 changing the size of the form --

21 MS. BOYD:

22 Correct.

23 MR. BROUSSARD:

24 -- that is a statutory
25 limitation?

1 MS. BOYD:

2 We just know that historically
3 that we've been able to add this. I
4 know the State of Massachusetts, for
5 example, these were some additional
6 recommendations we gave to them a
7 couple of years ago, and their form is
8 a two-page form as well. So maybe an
9 opportunity to look and maybe compare
10 what they have on their form and how
11 they have it designated and the font
12 and things of that nature might be
13 applicable, just a recommendation.

14 MR. BROUSSARD:

15 And my original first question
16 was to your question about whether or
17 not the rule apparently preempts the
18 ePA. I'm not sure if that was the
19 gist of your question, whether or not
20 the rule would preempt an ePA.

21 MS. BOYD:

22 Yes, sir.

23 MR. BROUSSARD:

24 And when the Board wrote the
25 rule, they required that the form that

1 was promulgating, either in written
2 form or its electronic equivalent, my
3 members were anticipating that would
4 cover an ePA. Do you have a concern
5 that that language does not address
6 that?

7 MS. BOYD:

8 I don't necessarily have a
9 concern, other than when it says
10 electronic equivalent. Sometimes it
11 can be interpreted that if all of the
12 questions that are on the form are not
13 asked in the ePA process, then it's
14 not an equivalent. Not every question
15 that might be on this form would be
16 necessary for every patient and every
17 drug that might require a PA. Those
18 are some of the difficulties that we
19 have run into in jurisdictions where
20 there is a uniform PA form, an ePA is
21 present. An ePA is done in every
22 jurisdiction today. So that's some of
23 the difficulty, just to make sure that
24 we're not saying the ePA process must
25 be identical or the questions that are

1 here must be identical in the ePA
2 process. Because that would -- that
3 would be a reversal of the expeditious
4 process today.

5 Does that make sense?

6 **MR. BROUSSARD:**

7 I think it does, and it gets to
8 the heart of the question, I think why
9 the legislature wanted a uniform
10 approach, and the mandate is to create
11 a uniform approach. Our Board did not
12 want to impede the use of ePA,
13 recognizing that we have a statutory
14 mandate. Thank you.

15 **MS. BOYD:**

16 Thank you.

17 **DR. THOMAS:**

18 Ms. Boyd, CoverMyMeds only does
19 e-Prescribing; is that correct?

20 **MS. BOYD:**

21 No, ma'am. We do not do
22 e-Prescribing. We are not an
23 e-Prescribing network. We are an
24 electronic prior authorization
25 network. We do not e-Prescribe today.

1 Although, the script standard that
2 NCPDP created houses both the
3 transactions for e-Prescribing and
4 ePA.

5 DR. THOMAS:

6 Okay.

7 MS. BOYD:

8 So we do not do e-Prescribing
9 today. We only do -- and we do fax as
10 well. So not every PA that goes --
11 like I said, we have the forms in
12 there, and those will go fast as well.

13 DR. THOMAS:

14 And then Dr. Culotta, I believe,
15 had --

16 DR. CULOTTA:

17 Ms. Boyd, when you talked about
18 for a physician provider, a provider
19 who administers drugs in the office,
20 with the reinitiation and re-upping of
21 patents under the ACA, a lot of drugs
22 that used to be very inexpensive and
23 very easy to stock in a doctor's
24 office have gone up traumatically, for
25 example, bicillin to treat syphilis.

1 Louisiana has one of the highest
2 syphilis rates in the country, and
3 they really do need to know that
4 they're going to be administered.
5 Because, remember, these companies use
6 cost as well as efficacy to determine
7 PA. So we ought to be able to say
8 you're going to get it filled and
9 bring it to the doctor's office and
10 get it so we can document it. So with
11 regard to your request that it
12 wouldn't be necessary, how are you
13 going to address drugs like that, like
14 bicillin and those very expensive
15 reauthorized drugs under the ACA?

16 MS. BOYD:

17 I think my response to you as
18 the professionals and those who truly
19 understand your patient need, that if
20 keeping that in there because of the
21 syphilis administration drugs, we
22 would be perfectly fine with that.
23 You know, I don't think that our
24 clinicians thought through every
25 single scenario that might be there.

1 They we're really honing in on the
2 specialty side because we have seen a
3 lot of issues being addressed on
4 specialty with the rise in cost and
5 their availability now.

6 **DR. CULOTTA:**

7 Because bicillin has gone out
8 the roof in price.

9 **MS. BOYD:**

10 We would be willing to remove
11 that recommendation.

12 **DR. CULOTTA:**

13 Thank you.

14 **DR. VALENTINE:**

15 Thank you, Ms. Boyd. We
16 appreciate it.

17 **MS. BOYD:**

18 Thank you.

19 **MR. BERGERON:**

20 Madam President, may I suggest
21 the Board stand down for a bit? We
22 have some more time here in case
23 anyone comes up and wishes to offer
24 comments.

25 **DR. VALENTINE:**

1 Sure. Okay. So we can take a
2 break.

3 (A brief break was taken at 9:37 a.m.)

4 **MR. BERGERON:**

5 Well, thank you very much. The
6 time now is 10:20. Ms. Arceneaux, do
7 we have any more speaker request
8 forms?

9 **MS. ARCENEUX:**

10 No, sir.

11 **MR. BERGERON:**

12 Is anyone waiting to address
13 the --

14 **MS. ARCENEUX:**

15 No, sir.

16 **MR. BERGERON:**

17 Thank you very much. Thank you,
18 Dr. Winstead. Mr. Broussard is
19 welcome to remain, if you will.
20 Dr. Culotta will be here. And should
21 anyone else appear, you are more than
22 welcome to accept whatever comments
23 they may wish to offer.

24 **MR. BROUSSARD:**

25 Madam President, and members,

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thank you very much for your generous
hospitality and collaboration in this
process. Thank you very much.

DR. VALENTINE:

Thank you, Mr. Broussard.
(The proceedings were concluded at
10:18 a.m.)

C E R T I F I C A T E

I, SHELLEY A. SAMPEY, Certified Court Reporter/Registered Professional Reporter, in and for the State of Louisiana, do hereby certify that these proceedings were reported by me in stenotype and transcribed by me or under my personal direction and supervision, and is a true and correct transcript to the best of my ability and understanding;

That the transcript has been prepared in compliance with transcript format guidelines required by statute or by rules of the board, as described on the website of the board;

That I have acted in compliance with the prohibition on contractual relationships as defined by Louisiana Code of Civil Procedure Article 1434 and in rules and advisory opinions of the board;

That I am not of counsel, not related to counsel, nor to the parties hereto, and am in no way interested in the outcome of this matter.

SHELLEY A. SAMPEY, CCR
Certified Court Reporter
State of Louisiana, #93011

1 PUBLIC HEARING 1
2 FRIDAY, SEPTEMBER 28, 2018
3 THE LOUISIANA STATE
4 BOARD OF MEDICAL EXAMINERS
5 630 CAMP STREET
6 NEW ORLEANS, LOUISIANA 70130
7 *****
8
9 A Public Hearing was held at the
10 Louisiana State Board of Medical Examiners
11 Office commencing at 9:01 a.m.
12
13 **PANEL MEMBERS:**
14 James A. Taylor, Jr., MD
15 Terrie R. Thomas, MD
16 Christy L. Valentine, MD
17 Daniel K. Winstead, MD
18 Roderick V. Clark, MD
19 Kweli J. Amusa, MD
20 Vincent A. Culotta, Jr., MD
21 LSBME Executive Director
22
23 **MODERATOR:**
24 Philip Bergeron, Esq.
25
ALSO PRESENT:
Malcolm Broussard, R.Ph,
Executive Director
Louisiana Board of Pharmacy
REPORTED BY: Shelley A. Sampey, CCR
Certified Court Reporter
State of Louisiana, #93011

1 PROCEEDINGS 2
2 **DR. VALENTINE:**
3 Good morning everyone. I am
4 Dr. Christy Valentine. I'm the
5 Louisiana State Board of Medical
6 Examiners president. And I have asked
7 Mr. Phil Bergeron to moderate today's
8 hearing. He's going to ensure that
9 everyone that would like an
10 opportunity to speak has that
11 opportunity.
12 So thank you, Phil, this
13 morning.
14 **MR. BERGERON:**
15 Thank you, Dr. Valentine.
16 Ladies and gentlemen, welcome. This
17 meeting is being called, it's a joint
18 meeting by the Louisiana State Board
19 of Medical Examiners and the Louisiana
20 State Board of Pharmacy. I should say
21 a joint hearing. And they're
22 convening to receive public comments,
23 information, views, data and arguments
24 from all interested persons and
25 organizations on some proposed rules

3 governing the Uniform Prescription
4 Drug Prior Authorization Form. This
5 form is mandated by Act 423 of the
6 2018 regular session of the
7 legislature.
8 Mr. Malcolm Broussard, who is
9 the executive director of the
10 Louisiana State Board of Pharmacy is
11 here as well. He's graciously allowed
12 me to make these opening comments. He
13 may have something to say after I
14 conclude the opening comments. But he
15 is here on behalf of the Pharmacy
16 Board to receive comments as well.
17 There are several members of the
18 Board present here today. From my
19 left, your right, we have Dr. Kweli
20 Amusa, Dr. Rod Clark, Dr. Daniel
21 Winstead, Dr. Terrie Thomas and
22 Dr. James Taylor. Of course, our
23 president has introduced herself,
24 Dr. Christy Valentine.
25 A few housekeeping issues
quickly. Two emergency exits on this
floor, one on my right to your left

4 next to the elevator, one on my left
5 at the far end of the hall. There are
6 restrooms at the far end of the hall
7 as well. If you would, please mute
8 your phones and avoid talking to
9 anyone in the audience while the
10 speakers are talking.
11 We don't have a very big
12 audience today, so a lot of the
13 formalities will be skipped over.
14 Notice of Intent for these rules was
15 published in the Louisiana Register in
16 accordance with the Louisiana
17 Administrative Procedure Act. They
18 were electronically filed on both the
19 Board's web page of the LSBME and the
20 Pharmacy Board noticing the intent and
21 the proposed rules and of this hearing
22 that is being held this morning at
23 9 o'clock. Let Ms. Reporter please
24 note that the hearing started about
25 three minutes ago. It's five after 9
now.
Copies of the proposed rules are
available from Ms. Arceneaux. These

5

1 are the rules that were published in
 2 the August 2018 edition of the
 3 Louisiana Register, Volume 44,
 4 Number 08. Copies are available, as
 5 I've said. These records, these
 6 documents, will be made part and
 7 parcel of this rule-making effort, as
 8 will all of the written comments
 9 received during the comment period.

10 I will note for the audience and
 11 the folks present here that the
 12 comment period concludes at noon
 13 today. So if someone has written
 14 comments they would like to offer
 15 following this hearing, they can offer
 16 them in writing, electronically or
 17 hard copy to Ms. Arceneaux or to
 18 Mr. Broussard by noon today.

19 The proceedings are being
 20 recorded by a recorder, by a
 21 stenographer, and will be made
 22 available to the members of the Boards
 23 for their review in the rule-making
 24 process.

25 Just a few procedural rules

6

1 before we hear the comments. First of
 2 all, if you wish to offer a comment,
 3 please obtain a speaker request card
 4 from Ms. Arceneaux identifying the
 5 name of the organization and the
 6 capacity in which you are appearing
 7 today so that we will have that
 8 information available. Also, please
 9 sign the attendee register so we will
 10 know who is present and wishing to
 11 speak. And, finally, because these
 12 are joint rules that have been noticed
 13 for intent, please specify whether
 14 your comments are directed to the
 15 Pharmacy Board, the Medical Board or
 16 both. The attendance register and the
 17 speaker cards, of course, are
 18 necessary for the Board to fulfill its
 19 obligations under the law, both to
 20 report to the legislature on the
 21 comments received and to respond to
 22 you with respect to the Board's answer
 23 to your comments.

24 We have a microphone here and a
 25 chair in the front of the room.

7

1 Anyone wishing to speak, I would ask
 2 that you come up to the microphone,
 3 make sure it's on, state your name,
 4 the organization that you're
 5 representing and the capacity, and
 6 then proceed to give your comments.
 7 Keep in mind that today's meeting is
 8 to receive public comments, not to
 9 respond to them. So while the Board
 10 may ask you questions, it's not a
 11 hearing capacity to respond to those
 12 questions. That, of course, will be
 13 handled when the Board issues written
 14 responses to all the comments that
 15 have been offered.

16 I believe, Madam President, we
 17 have reserved an hour for this
 18 morning's hearing?

19 **DR. VALENTINE:**
 20 Yes, we have.

21 **MR. BERGERON:**
 22 So, again, after that time
 23 frame, written comments can still be
 24 received if directed to either
 25 Ms. Arceneaux with the Board of

8

1 Medical Examiners or Mr. Broussard
 2 here on behalf of the Board of
 3 Pharmacy.

4 Mr. Broussard, do you have
 5 anything that I've omitted that you
 6 would like to add?

7 **MR. BROUSSARD:**
 8 Good morning, Madam President
 9 and members. We appreciate the
 10 Board's invitation to collaborate with
 11 this public hearing on a rule that we
 12 are jointly promulgating.
 13 Mr. Bergeron did an excellent job in
 14 summarizing the proceedings.

15 The only thing we would add is
 16 we would like to put into the record
 17 that we have received two written
 18 correspondences prior to the beginning
 19 of today's hearing. And to identify
 20 those for us, the first is a letter
 21 from the firm Coils & Braden (assumed
 22 spelling) in Chicago, and it was
 23 received in our office at the Board of
 24 Pharmacy in Baton Rouge yesterday on
 25 the 27th, and it is primarily

9

1 questions and not comments. And today
 2 we received a letter from CoverMyMeds,
 3 and we understand that person is in
 4 the audience. They may choose to
 5 supplement their written comments, and
 6 we appreciate these are questions as
 7 well as comments. So those are the
 8 two written documents we have received
 9 prior to today's hearing.

10 Thank you, and we'll be here to
 11 participate in the hearing till the
 12 very end. Thank you very much.

13 **MR. BERGERON:**
 14 Thank you.

15 **DR. CULOTTA:**
 16 Mr. moderator, Madam President,
 17 and Board Members, we also received a
 18 letter from CoverMyMeds as well, and
 19 we have got copies for everybody, and
 20 we'll get them to you right now.

21 **MR. BERGERON:**
 22 Thank you, Mr. Broussard,
 23 Dr. Culotta.
 24 With those comments, we do have
 25 one speaker request card that has been

10

1 completed by Ms. Kim Boyd. Ms. Boyd,
 2 thank you for joining the Boards this
 3 morning. If you have anything to add
 4 to the communication that both Boards
 5 received this morning, please feel
 6 free to come up to the speaker table,
 7 identify your organization and
 8 capacity and proceed to give us your
 9 comments.

10 **MS. BOYD:**
 11 I think I'm the only one in the
 12 room. I'm not used to that.
 13 Thank you, Madam President,
 14 members of the Board, directors,
 15 associate directors. My name is Kim
 16 Boyd. I am director of industry
 17 relations and government affairs at
 18 CoverMyMeds. I've been on board at
 19 CoverMyMeds for about three years now,
 20 but been in the health care space
 21 probably, well, about 20 years now.
 22 I'm not as experienced as I'm sure
 23 many of you here are. I definitely am
 24 not a doctor. But I do appreciate
 25 your time today. This is a very

11

1 important piece of regulation to the
 2 health care industry, more
 3 specifically to the medication PA
 4 process.

5 By way of background -- and you
 6 have the letter here, so I'm not going
 7 to regurgitate everything that's in
 8 the letter. But there are some points
 9 I would like to make that, you know,
 10 by way of background, CoverMyMeds is a
 11 health care IT company. We were
 12 formed in 2008. We're out of
 13 Columbus, Ohio. I'm from Nashville,
 14 if you can't hear the accent. But
 15 I've been on board with them about
 16 three years now.

17 In 2008, they formed to help
 18 expedite or improve the medication PA
 19 process. Our founder who is -- I
 20 think he's 38, and highly intelligent,
 21 more intelligent than I care to think
 22 I would ever be, was approached by a
 23 really good friend of his who is a
 24 doctor and said: I have a real
 25 problem. I have patients who need

12

1 their medication and it's taking me
 2 days, if not weeks, because of the
 3 laborious PA process to get the
 4 patient the medication. Matt, I know
 5 you're a really smart guy, you're a
 6 technical guy. What can you do to
 7 help me?

8 So therein formed CoverMyMeds.
 9 Basically, the doctor said: I can't
 10 get my patients' meds covered. So
 11 that's where the name came from. So
 12 what we started to do in 2008 is to
 13 build this library of all of the prior
 14 authorization forms that were in the
 15 industry. So as a way for the
 16 physician to quickly find those forms
 17 instead of having to search each
 18 state's website or each directory, go
 19 to one location, go to a portal.
 20 Today we still house roughly 14,000
 21 forms in that portal. We do process
 22 PAs nationwide, so that's why there is
 23 this huge library of forms. About
 24 9,000 of them are still currently in
 25 play, a lot of them associated more so

13

1 with Medicaid, but there are many on
 2 the commercial side and many -- you
 3 know, there's Medicare as well. So we
 4 cover all plans, all medications
 5 through the CoverMyMeds process.
 6 But what we started to do
 7 shortly thereafter, there was a
 8 standard that was named by the
 9 National Council for Prescription Drug
 10 Programs, or NCPDP. They are the
 11 standards development organization
 12 that standardizes everything for the
 13 pharmacy community. They have been an
 14 organization for about 40 years now.
 15 They have roughly 26 standards on
 16 their books. Each day task groups
 17 work to evolve those standards as the
 18 industry evolves.
 19 So about 10 years ago the NCPDP
 20 script standard was adopted, was
 21 created. That standard houses the
 22 e-Prescribing standard as well as the
 23 ePA transactions that are present
 24 today and utilized today. So we went
 25 from a very, you know, paper-driven

14

1 process -- and the PA process for
 2 paper takes about three to five days
 3 to get completed. So the patient gets
 4 their prescription from the pharmacy,
 5 whether it's -- excuse me, not from
 6 the pharmacy, from the provider.
 7 Whether it's e-Prescribed to the
 8 pharmacy or it is written by hand, the
 9 ePA process can still take place and
 10 it does today. So that standard
 11 allows for that. It is a four-part
 12 transaction that is done computer to
 13 computer that allows the prescriber to
 14 quickly identify the patient, the
 15 need, the medication, and it's done in
 16 real time versus the paper process
 17 which takes three to five days. The
 18 ePA process takes about one day for
 19 the patient to get a determination
 20 from the plan, sometimes 10 minutes.
 21 It really just depends on the plan and
 22 their integration at this point.
 23 Today CoverMyMeds does a little
 24 over two million prior authorizations
 25 a month. We've helped over one

15

1 hundred million patients get the
 2 medications they need to live healthy
 3 lives. So while we are not completely
 4 adverse to the adoption of a Uniform
 5 Prescription Form, and we understand
 6 that SB29 is calling for the two
 7 Boards to come together and create
 8 this form, we definitely have some
 9 questions and we also wanted to make
 10 sure that the Boards were well aware
 11 that the State of Louisiana is well
 12 down the pathway of adopting the ePA.
 13 Through CoverMyMeds right now,
 14 we cover about 75 percent of those PAs
 15 that come to us are done
 16 electronically today versus via the
 17 paper form. So we want to ensure as
 18 the Boards consider this rule-making
 19 that there is some clarification that
 20 is put in the rules. Because I know
 21 the SB29 indicated that this form
 22 would not need to be utilized if
 23 e-Prescribing was done or if it was a
 24 specialty medication. So what, again,
 25 we would like the Board to help us

16

1 understand is that if a payer and a
 2 provider and/or a pharmacy are
 3 completing the PA process today
 4 electronically that they would not
 5 need to revert to this form and begin
 6 using this form versus using the ePA
 7 process. Patients know pretty much
 8 that day whether or not their
 9 medications are covered and can pick
 10 it up at the pharmacy versus having to
 11 leave the pharmacy without a
 12 medication in hand waiting for the
 13 paper form to get completed. So,
 14 again, that is one thing that I would
 15 like clarification from the Board on
 16 is to make sure that the ePA process
 17 will not be deterred or be overwritten
 18 by this form that is adopted by the
 19 two Boards.
 20 Secondly, I also want to make
 21 sure that should a prescriber pick out
 22 this uniform form and it happens to be
 23 a prescription that was electronically
 24 prescribed that the plans do not say,
 25 oh, it was electronically prescribed,

17

1 you don't have to use this form, use
 2 another form, that the plan will
 3 continue with the PA process through
 4 the Uniform Prescription Drug Form and
 5 continue to move that process
 6 downstream. We have seen instances
 7 where the incorrect form was pulled
 8 and/or used and a plan has denied the
 9 PA, saying, you've used the wrong
 10 form. So that's really what I'm
 11 trying to get at is to make sure that
 12 even if the prescriber pulls this form
 13 and uses it for a e-Prescribed
 14 medication or for a specialty
 15 medication that the process will
 16 continue and the patient will not have
 17 to wait or the prescriber will not
 18 have to start over. That does not
 19 bode well for patient access. And I
 20 think at the end of the day we're
 21 trying to get the patients what they
 22 need to live healthy lives.
 23 So those were really the three
 24 questions or clarifications that we
 25 would seek from the Board on this.

18

1 There are a couple of comments that
 2 are -- we called the PDA content team.
 3 They're the ones who manage all of
 4 those forms, and they've seen the
 5 14,000 forms a lot. So I asked that
 6 team for their comments about the
 7 current proposed form and what is on
 8 it, and they gave me a few comments to
 9 provide to you for clarification as
 10 well, and they are included in the
 11 letter that I'm submitting.
 12 But one of the comments that is
 13 there that I would like to highlight
 14 that is: The provider -- excuse me, I
 15 have a cold, I'm so sorry -- the
 16 provider-administered drugs section
 17 would not be necessary on the current
 18 proposed form since the utilization of
 19 this section is usually for specialty
 20 medications only. And if this form is
 21 not to be used for specialty
 22 medications, there should really not
 23 be an area for that. Secondly, since
 24 this form is not necessary for use if
 25 it is a specialty medication or the

19

1 prescription was e-Prescribed, we
 2 suggest placing a message or a
 3 notation somewhere on the form letting
 4 the physician know that this form will
 5 not be utilized in those two
 6 instances, just to give them
 7 clarification.
 8 Some other recommendations they
 9 had was to expand the tried and failed
 10 section on the form to accommodate for
 11 additional drug history to make sure
 12 that all necessary drug history could
 13 be completed on the form.
 14 Also, to create a separate
 15 action for non-pharmacologic
 16 therapies, to also add a section or a
 17 question or expansion of the clinical
 18 criteria section. I'm sure most of
 19 you, as physicians, understand that
 20 providing the clinical efficacy
 21 information is usually paramount to
 22 getting a determination made for a
 23 medication PA. It's one of the most
 24 critical pieces of the PA process.
 25 Also, to add a field for a

20

1 provider to indicate the urgency of
 2 this request. There are many times
 3 that a patient has an urgent need for
 4 the medication that is being
 5 requested. And usually a plan, when
 6 they are given that information, will
 7 put it through an expedited process as
 8 required by law.
 9 Also, to add -- excuse me -- a
 10 date of diagnosis ICD-10 area. And
 11 the diagnosis description area should
 12 also be given additional information.
 13 There are many times that you --
 14 you obviously probably know this --
 15 you have a primary diagnosis, but you
 16 also have secondary symptoms, and so
 17 there are medications that could
 18 potentially be prescribed for
 19 off-label use from a diagnosis. And
 20 being able to identify those reasons
 21 in that area, we think, would be
 22 beneficial.
 23 Also, and last but not least,
 24 consider adding a note instructing the
 25 provider to attach any appropriate or

21

1 applicable documentation so the plan
 2 doesn't have to come back and ask for
 3 that information, again delaying the
 4 PA process.
 5 And that is all for me. Thank
 6 you so much. And, of course, I'm
 7 happy to answer any questions the
 8 Board may have. But if not, I really
 9 appreciate your time today.

10 **MR. BERGERON:**
 11 Just a clarification. The
 12 comments that you have are directed to
 13 both Boards?

14 **MS. BOYD:**
 15 That's correct, sir.

16 **MR. BERGERON:**
 17 And aside from what is on -- I
 18 think you've outlined your comments on
 19 the form today. Is there anything
 20 else that you would like to add? I
 21 mean, your comments kind of duplicated
 22 what is on the written form -- written
 23 communication.

24 **THE WITNESS:**
 25 Right. Yes, sir.

22

1 **MR. BERGERON:**
 2 Okay. I just wanted -- Do any
 3 of the Board members have any
 4 questions this morning?

5 **DR. TAYLOR:**
 6 Thank you for coming today. I'm
 7 actually doing the real time testing
 8 to some of my gynos and colleagues,
 9 and they seem to like your process
 10 better than the old process, frankly.

11 **MS. BOYD:**
 12 Thank you.

13 **DR. TAYLOR:**
 14 And I was looking over your
 15 recommendations before the meeting.
 16 Actually, some of these, I believe,
 17 make a good deal of sense. I did want
 18 to drill down one question, though.
 19 Provider-administered drugs section
 20 wouldn't be necessary. In your
 21 experience, are there any
 22 physician-administrated drugs that are
 23 not also designated as specialty
 24 drugs? In other words, would there be
 25 a situation -- and, again, I'm

23

1 thinking of a matter like for a
 2 vaccination that as a pharmacy benefit
 3 they would have to get that covered or
 4 something like whether that be as an
 5 every-six-month osteoporosis
 6 injection. Are there any medications
 7 that you're aware of that would fall
 8 outside the specialty drug that would
 9 be given in the physician's office or
 10 that patient could actually
 11 self-administer and not choose to
 12 administer in a physician's office?

13 **MS. BOYD:**
 14 Great question. I can't think
 15 of any -- anyone. I did ask the
 16 group, you know, in the content team,
 17 and we have six clinical pharmacists
 18 who are on staff there. I know the
 19 two they reviewed, and that those were
 20 their comments. So I can go back and
 21 ask more specifically, and I'm happy
 22 to do that for the Board.

23 **DR. TAYLOR:**
 24 Again, it's an unusual event,
 25 but I wouldn't say that it's

24

1 nonexistent, at least in my practice.
 2 And also back up for -- and to get a
 3 better idea, because I actually get
 4 CoverMyMeds' faxes -- or responses at
 5 my office as well. How do you get --
 6 you as a company -- get involved in
 7 the process? Because sometimes I'll
 8 get a patient, and I'll see the form
 9 with the code numbers on it, and
 10 sometimes I don't. Are you contracted
 11 to the insurance companies? Are you
 12 contracted to the pharmacy medical
 13 manager? How does CoverMyMeds come
 14 into the process, and what's your
 15 relationship on the front and back end
 16 of that process?

17 **MS. BOYD:**
 18 Sure. So the CoverMyMeds
 19 process, we do not charge providers
 20 nor pharmacies to utilize our process.
 21 We are connected with all pharmacies.
 22 A hundred percent of pharmacies are
 23 connected through ePA. Providers can
 24 utilize -- they can log in
 25 individually and use our portal and

25

1 still do ePA through a portal or we
 2 are connected directly with their
 3 EHRs. So we have those -- those are
 4 how we connect with those two pieces
 5 of the puzzle. It is the plans who
 6 compensate CoverMyMeds for the
 7 transaction process.

8 **DR. TAYLOR:**
 9 And I don't know if you haven't
 10 answered this question, but would it
 11 be your experience that a majority of
 12 those interactions actually start from
 13 the pharmacy?

14 **MS. BOYD:**
 15 Correct. Roughly -- it used to
 16 be a little bit higher, but presently
 17 about 65 to 69 percent on any given
 18 state. The pharmacy is the one who
 19 initiates the PA. So the prescriber
 20 will prescribe either paper
 21 e-Prescribing, you go to pick up your
 22 prescription and it says, sorry, it's
 23 been rejected because it needs a PA.
 24 So the pharmacy will -- we have what
 25 is called an easy button inside the

26

1 majority of the 65,000 pharmacies
 2 nationwide, and they just touch that
 3 button and it automatically creates
 4 the start of the PA. So it does the
 5 demographic information, it puts in
 6 the patient medication information,
 7 and it sends it off to the provider to
 8 the plan. And the plan will then send
 9 the clinical criteria question set
 10 which is unique to the patient and the
 11 medication. That is the difference
 12 between a form and the ePA process as
 13 well. A form has general questions on
 14 it. Most of the time the plan comes
 15 back and asks the prescriber more
 16 questions that are specific to you or
 17 me and our medication. So the
 18 pharmacy will start it off due to that
 19 rejection, and then the provider and
 20 the plan will then take up the process
 21 electronically. Again, the clinical
 22 questions that are asked that is
 23 unique to you or I and the medication
 24 and the doctor's system either pulls
 25 the information and answers it or

27

1 someone within the physician's office
 2 will answer those few questions and
 3 send it back to the plan
 4 electronically.

5 In the ePA process, just to dig
 6 a little deeper, auto determinations
 7 are done. People are not picking up a
 8 piece of paper or a book and going
 9 through this flow chart of questions
 10 and seeing what was answered "yes,"
 11 "no," that sort of thing. The systems
 12 are doing that. That's why ePA is so
 13 much faster, because the auto
 14 determination happens through ePA.

15 Does that answer your question?

16 **DR. TAYLOR:**
 17 Yes. Thank you.

18 **MS. BOYD:**
 19 Perfect. Thank you.

20 **MR. BERGERON:**
 21 I'm looking -- just out of
 22 curiosity, I'm looking through your
 23 suggestions on Page 2 of your
 24 communication.

25 **THE WITNESS:**

28

1 Yes, sir.

2 **MR. BERGERON:**
 3 And so your first one is to the
 4 provider-administered drugs section
 5 wouldn't be necessary since this form
 6 is not to be utilized for specialty
 7 medications. And then again, since
 8 this form is not necessary for use if
 9 the prescription for the medication or
 10 the prescription, if it was e-filed,
 11 we suggest placing a message at the
 12 top. Could not that be accomplished
 13 simply by the -- by "N/A," by use of
 14 the not applicable, not applicable to
 15 this drug?

16 **MS. BOYD:**
 17 I'm so sorry. Could you repeat
 18 that question?

19 **MR. BERGERON:**
 20 Could the present form not be
 21 utilized simply with the notation "not
 22 applicable, specialty drug."

23 **MS. BOYD:**
 24 Correct. Correct. And I think
 25 that's the recommendation we're making

29

1 here, if we could put someplace on the
 2 form that specialty medication, not
 3 applicable, e-Prescribed, not
 4 applicable. So when the physician
 5 pulls up -- so, for example, in our
 6 portal where we house all of these
 7 forms, the prescriber will go in and
 8 pick the appropriate form or format to
 9 begin that process if they go through
 10 the portal process. We want to make
 11 sure that they pick the right one. So
 12 if it's -- the question's still going
 13 to come into play -- the question
 14 still comes into play as who defines
 15 specialty as well. I did not put that
 16 in my comments here, but who defines
 17 what's a specialty drug.
 18 You could have a prescriber
 19 thinking they're doing a specialty
 20 drug for Blue Cross Blue Shield, they
 21 send it over, Blue Cross Blue Shield
 22 says, no, we consider that a specialty
 23 drug. So the definition of specialty
 24 still comes into play as well.
 25 There's no universal definition of

30

1 specialty in our -- we've got CMS who
 2 has a definition. But there's no real
 3 true universal definition that's been
 4 defined yet of what a specialty drug
 5 is. So I think if we could get some
 6 clarification so they know which form
 7 to pick and where to go so it doesn't
 8 delay the process...
 9 **MR. BERGERON:**
 10 Next question: Expand the tried
 11 and failed section to accommodate more
 12 drug history. What specific section
 13 are you referring to?
 14 **MS. BOYD:**
 15 I'm sorry, sir. I don't have
 16 the form in front of me. I might have
 17 it in front of me here.
 18 **MR. BERGERON:**
 19 It's in the rule. Do you have a
 20 copy?
 21 **MS. BOYD:**
 22 It was in the rule. I do not
 23 now. Do you have one, Rita?
 24 **MR. BERGERON:**
 25 Ms. Arceneaux, could you get a

31

1 copy? I just want to make sure that
 2 we understand exactly the section that
 3 you're referring to.
 4 **MS. BOYD:**
 5 And my apologies for not
 6 notating the section specifically.
 7 Let me see if I can find it. Sir,
 8 where it says continue -- so under
 9 Section IV: Prescription drug
 10 information, where it says: To the
 11 best of your knowledge this medication
 12 is for a new therapy or a continuation
 13 of therapy or a reauthorization part,
 14 that is what our team would call a
 15 tried and fail. Is it a
 16 reauthorization, is it something that
 17 you were taking before, and put
 18 information in there. Because we do
 19 get a lot of questions. We do
 20 basically step therapy. So PA in the
 21 system could be, you know, a step
 22 therapy request, an exception to an
 23 off label, quantity limit, things of
 24 that nature. So there could be some
 25 additional section here that a

32

1 prescriber can indicate that a former
 2 medication that might be on a
 3 formulated benefit that would not
 4 require PA has been tried and failed.
 5 Does that make sense?
 6 **MR. BERGERON:**
 7 Clarification also: Create a
 8 separate section for non-pharmacologic
 9 therapies. Section VII currently
 10 applies to both pharmacologic and
 11 non-pharmacologic treatments. Is that
 12 -- is it your view that that needs to
 13 be supplemented or changed?
 14 **MS. BOYD:**
 15 Let me go back. The
 16 recommendation was to actually split
 17 those out and make those two separate
 18 sections so you have pharmacologic and
 19 non-pharmacologic. The recommendation
 20 would be to split those two out just
 21 for clarity.
 22 **MR. BERGERON:**
 23 A field to indicate the urgency
 24 of the request, I think is --
 25 **MS. BOYD:**

33

1 Yes, sir. On many forms you'll
 2 have at the top, Urgent/Nonurgent, a
 3 box that could be checked. On many
 4 other standard forms there's a place
 5 to designate that. Usually it is a
 6 check box or a line that could be
 7 checked.

8 **MR. BERGERON:**
 9 I think I just wanted to make
 10 sure the Board had clarification on
 11 those issues. Thank you so much.

12 **MS. BOYD:**
 13 Thank you. I appreciate it.

14 **DR. VALENTINE:**
 15 Yes, Mr. Broussard?

16 **MR. BROUSSARD:**
 17 Madam President, if I may, I
 18 think my members would appreciate if I
 19 would ask Ms. Boyd some questions.

20 **DR. VALENTINE:**
 21 Absolutely.

22 **MR. BROUSSARD:**
 23 I'll pick up this last one first
 24 asking for a separate section for the
 25 non-pharmacologic therapies. Knowing

34

1 that the existing law that legislation
 2 addressed at 423, existing law limits
 3 the size of the form to two pages, if
 4 you wanted to create another section
 5 to expand, are you willing to collapse
 6 something else so that it could fit,
 7 that would make it all fit. I think
 8 the drafters of the form are trying to
 9 fit as much as they could into the
 10 two-page limitation.

11 **MS. BOYD:**
 12 Absolutely. I'm wondering on
 13 the non-pharmacologic area -- and I
 14 can never say that right, so my
 15 apologies -- if only a couple of lines
 16 would be sufficient. It looks like it
 17 if you look at -- so right now, would
 18 this be a three-page directive? Would
 19 this be a three-page that we're
 20 looking at right now?

21 **MR. BROUSSARD:**
 22 What we're looking at now is a
 23 two-page form.

24 **MS. BOYD:**
 25 Okay. There is a little wiggle

35

1 room. I would suggest maybe if you
 2 can expand that out maybe giving it
 3 only a couple of sections or a couple
 4 of lines if you could do that. I'm
 5 not sure -- they did not indicate when
 6 we -- I reviewed it and they reviewed
 7 it. We didn't see anything that
 8 should be necessarily taken out of
 9 here. There was coverage that was
 10 applicable to many other forms, so we
 11 didn't see any area to really remove.

12 **MR. BROUSSARD:**
 13 And so the same question applies
 14 to all the other items that you wish
 15 to add. It becomes a matter of,
 16 logistically, how would the form
 17 creators manage all the data fields
 18 within the two-page limit when the
 19 Boards do not have the option of
 20 changing the size of the form --

21 **MS. BOYD:**
 22 Correct.

23 **MR. BROUSSARD:**
 24 -- that is a statutory
 25 limitation?

36

1 **MS. BOYD:**
 2 We just know that historically
 3 that we've been able to add this. I
 4 know the State of Massachusetts, for
 5 example, these were some additional
 6 recommendations we gave to them a
 7 couple of years ago, and their form is
 8 a two-page form as well. So maybe an
 9 opportunity to look and maybe compare
 10 what they have on their form and how
 11 they have it designated and the font
 12 and things of that nature might be
 13 applicable, just a recommendation.

14 **MR. BROUSSARD:**
 15 And my original first question
 16 was to your question about whether or
 17 not the rule apparently preempts the
 18 ePA. I'm not sure if that was the
 19 gist of your question, whether or not
 20 the rule would preempt an ePA.

21 **MS. BOYD:**
 22 Yes, sir.

23 **MR. BROUSSARD:**
 24 And when the Board wrote the
 25 rule, they required that the form that

37

1 was promulgating, either in written
 2 form or its electronic equivalent, my
 3 members were anticipating that would
 4 cover an ePA. Do you have a concern
 5 that that language does not address
 6 that?

7 **MS. BOYD:**
 8 I don't necessarily have a
 9 concern, other than when it says
 10 electronic equivalent. Sometimes it
 11 can be interpreted that if all of the
 12 questions that are on the form are not
 13 asked in the ePA process, then it's
 14 not an equivalent. Not every question
 15 that might be on this form would be
 16 necessary for every patient and every
 17 drug that might require a PA. Those
 18 are some of the difficulties that we
 19 have run into in jurisdictions where
 20 there is a uniform PA form, an ePA is
 21 present. An ePA is done in every
 22 jurisdiction today. So that's some of
 23 the difficulty, just to make sure that
 24 we're not saying the ePA process must
 25 be identical or the questions that are

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1 here must be identical in the ePA
 2 process. Because that would -- that
 3 would be a reversal of the expeditious
 4 process today.
 5 Does that make sense?

6 **MR. BROUSSARD:**
 7 I think it does, and it gets to
 8 the heart of the question, I think why
 9 the legislature wanted a uniform
 10 approach, and the mandate is to create
 11 a uniform approach. Our Board did not
 12 want to impede the use of ePA,
 13 recognizing that we have a statutory
 14 mandate. Thank you.

15 **MS. BOYD:**
 16 Thank you.

17 **DR. THOMAS:**
 18 Ms. Boyd, CoverMyMeds only does
 19 e-Prescribing; is that correct?

20 **MS. BOYD:**
 21 No, ma'am. We do not do
 22 e-Prescribing. We are not an
 23 e-Prescribing network. We are an
 24 electronic prior authorization
 25 network. We do not e-Prescribe today.

39

1 Although, the script standard that
 2 NCPDP created houses both the
 3 transactions for e-Prescribing and
 4 ePA.

5 **DR. THOMAS:**
 6 Okay.

7 **MS. BOYD:**
 8 So we do not do e-Prescribing
 9 today. We only do -- and we do fax as
 10 well. So not every PA that goes --
 11 like I said, we have the forms in
 12 there, and those will go fast as well.

13 **DR. THOMAS:**
 14 And then Dr. Culotta, I believe,
 15 had --

16 **DR. CULOTTA:**
 17 Ms. Boyd, when you talked about
 18 for a physician provider, a provider
 19 who administers drugs in the office,
 20 with the reinitiation and re-upping of
 21 patents under the ACA, a lot of drugs
 22 that used to be very inexpensive and
 23 very easy to stock in a doctor's
 24 office have gone up traumatically, for
 25 example, bicillin to treat syphilis.

40

1 Louisiana has one of the highest
 2 syphilis rates in the country, and
 3 they really do need to know that
 4 they're going to be administered.
 5 Because, remember, these companies use
 6 cost as well as efficacy to determine
 7 PA. So we ought to be able to say
 8 you're going to get it filled and
 9 bring it to the doctor's office and
 10 get it so we can document it. So with
 11 regard to your request that it
 12 wouldn't be necessary, how are you
 13 going to address drugs like that, like
 14 bicillin and those very expensive
 15 reauthorized drugs under the ACA?

16 **MS. BOYD:**
 17 I think my response to you as
 18 the professionals and those who truly
 19 understand your patient need, that if
 20 keeping that in there because of the
 21 syphilis administration drugs, we
 22 would be perfectly fine with that.
 23 You know, I don't think that our
 24 clinicians thought through every
 25 single scenario that might be there.

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1 They we're really honing in on the

2 specialty side because we have seen a

3 lot of issues being addressed on

4 specialty with the rise in cost and

5 their availability now.

6 **DR. CULOTTA:**

7 Because bicillin has gone out

8 the roof in price.

9 **MS. BOYD:**

10 We would be willing to remove

11 that recommendation.

12 **DR. CULOTTA:**

13 Thank you.

14 **DR. VALENTINE:**

15 Thank you, Ms. Boyd. We

16 appreciate it.

17 **MS. BOYD:**

18 Thank you.

19 **MR. BERGERON:**

20 Madam President, may I suggest

21 the Board stand down for a bit? We

22 have some more time here in case

23 anyone comes up and wishes to offer

24 comments.

25 **DR. VALENTINE:**

42

1 Sure. Okay. So we can take a

2 break.

3 (A brief break was taken at 9:37 a.m.)

4 **MR. BERGERON:**

5 Well, thank you very much. The

6 time now is 10:20. Ms. Arceneaux, do

7 we have any more speaker request

8 forms?

9 **MS. ARCENEAUX:**

10 No, sir.

11 **MR. BERGERON:**

12 Is anyone waiting to address

13 the --

14 **MS. ARCENEAUX:**

15 No, sir.

16 **MR. BERGERON:**

17 Thank you very much. Thank you,

18 Dr. Winstead. Mr. Broussard is

19 welcome to remain, if you will.

20 Dr. Culotta will be here. And should

21 anyone else appear, you are more than

22 welcome to accept whatever comments

23 they may wish to offer.

24 **MR. BROUSSARD:**

25 Madam President, and members,

43

1 thank you very much for your generous

2 hospitality and collaboration in this

3 process. Thank you very much.

4 **DR. VALENTINE:**

5 Thank you, Mr. Broussard.

6 (The proceedings were concluded at

7 10:18 a.m.)

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17 Procedure Article 1434 and in rules and

18 advisory opinions of the board;

19 That I am not of counsel, not related

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21 in no way interested in the outcome of this

22 matter.

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24

25

SHELLEY A. SAMPEY, CCR
 Certified Court Reporter
 State of Louisiana, #93011

counsel

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<p>(31:16)(34:6) sometimes (14:20)(24:7) (24:10)(37:10) somewhere (19:3) sorry (18:15)(25:22) (28:17)(30:15) sort (27:11) space (10:20) speak (2:10)(6:11)(7:1) speaker (6:3)(6:17) (9:25)(10:6)(42:7) speakers (4:7) specialty (15:24) (17:14)(18:19)(18:21) (18:25)(22:23)(23:8) (28:6)(28:22)(29:2) (29:15)(29:17)(29:19) (29:22)(29:23)(30:1) (30:4)(41:2)(41:4) specific (26:16)(30:12) specifically (11:3) (23:21)(31:6) specify (6:13) spelling (8:22) split (32:16)(32:20) staff (23:18) stand (41:21) standard (13:8)(13:20) (13:21)(13:22)(14:10) (33:4)(39:1) standardizes (13:12) standards (13:11) (13:15)(13:17) start (17:18)(25:12) (26:4)(26:18) started (4:21)(12:12) (13:6) state (1:3)(1:10)(1:25) (2:5)(2:18)(2:20)(3:8) (7:3)(15:11)(25:18) (36:4)(44:4)(44:19) state's (12:18) statute (44:8) statutory (35:24)(38:13) stenographer (5:21) stereotype (44:5) step (31:20)(31:21) still (7:23)(12:20) (12:24)(14:9)(25:1) (29:12)(29:14)(29:24) stock (39:23) street (1:5) submitting (18:11) sufficient (34:16) suggest (19:2)(28:11) (35:1)(41:20) suggestions (27:23) summarizing (8:14) supervision (44:5) supplement (9:5) supplemented (32:13) symptoms (20:16) syphilis (39:25)(40:2) (40:21) system (26:24)(31:21) systems (27:11)</p>	<p>talking (4:5)(4:7) task (13:16) taylor (1:14)(3:20) (22:5)(22:13)(23:23) (25:8)(27:16) team (18:2)(18:6) (23:16)(31:14) technical (12:6) terrie (1:14)(3:19) testing (22:7) thank (2:12)(2:15) (9:10)(9:12)(9:14)(9:22) (10:2)(10:13)(21:5) (22:6)(22:12)(27:17) (27:19)(33:11)(33:13) (38:14)(38:16)(41:13) (41:15)(41:18)(42:5) (42:17)(43:1)(43:3)(43:5) that you (20:13) therapies (19:16)(32:9) (33:25) therapy (31:12)(31:13) (31:20)(31:22) thereafter (13:7) therein (12:8) these (3:10)(4:11) (4:25)(5:5)(6:11)(9:6) (22:16)(29:6)(36:5) (40:5)(44:4) they've (18:4) things (31:23)(36:12) thinking (23:1)(29:19) thomas (1:14)(3:19) (38:17)(39:5)(39:13) though (22:18) thought (40:24) three (4:22)(10:19) (11:16)(14:2)(14:17) (17:23) three-page (34:18) (34:19) time (7:22)(10:25) (14:16)(21:9)(22:7) (26:14)(41:22)(42:6) times (20:2)(20:13) today (3:16)(4:9)(5:13) (5:18)(6:7)(9:1)(10:25) (12:20)(13:24)(14:10) (14:23)(15:16)(16:3) (21:9)(21:19)(22:6) (37:22)(38:4)(38:25) (39:9) today's (2:7)(7:7) (8:19)(9:9) together (15:7) top (28:12)(33:2) touch (26:2) transaction (14:12) (25:7) transactions (13:23) (39:3) transcribed (44:5) transcript (44:6)(44:7) (44:8) traumatically (39:24) treat (39:25) treatments (32:11) tried (19:9)(30:10) (31:15)(32:4) true (30:3)(44:6) truly (40:18) trying (17:11)(17:21) (34:8) two (3:24)(8:17)(9:8) (14:24)(15:6)(16:19)</p>	<p>(19:5)(23:19)(25:4) (32:17)(32:20)(34:3) two-page (34:10)(34:23) (35:18)(36:8)</p> <hr/> <p style="text-align: center;">U</p> <p>under (6:19)(31:8) (39:21)(40:15)(44:5) understand (9:3)(15:5) (16:1)(19:19)(31:2) (40:19) understanding (44:6) uniform (3:1)(15:4) (16:22)(17:4)(37:20) (38:9)(38:11) unique (26:10)(26:23) universal (29:25)(30:3) unusual (23:24) urgency (20:1)(32:23) urgent (20:3) urgent/nonurgent (33:2) used (10:12)(17:8) (17:9)(18:21)(25:15) (39:22) uses (17:13) using (16:6) usually (18:19)(19:21) (20:5)(33:5) utilization (18:18) utilize (24:20)(24:24) utilized (13:24)(15:22) (19:5)(28:6)(28:21)</p> <hr/> <p style="text-align: center;">V</p> <p>vaccination (23:2) valentine (1:15)(2:2) (2:4)(2:15)(3:22)(7:19) (33:14)(33:20)(41:14) (41:25)(43:4) versus (14:16)(15:16) (16:6)(16:10) via (15:16) view (32:12) views (2:23) vii (32:9) vincent (1:17) volume (5:3)</p> <hr/> <p style="text-align: center;">W</p> <p>wait (17:17) waiting (16:12)(42:12) wanted (15:9)(22:2) (33:9)(34:4)(38:9) web (4:16) website (12:18)(44:9) weeks (12:2) welcome (2:16)(42:19) (42:22) well (3:9)(3:14)(4:4) (9:7)(9:18)(10:21)(13:3) (13:22)(15:10)(15:11) (17:19)(18:10)(24:5) (26:13)(29:15)(29:24) (36:8)(39:10)(39:12) (40:6)(42:5) we've (14:25)(30:1) (36:3) whatever (42:22) what's (24:14)(29:17) whether (6:13)(14:5) (14:7)(16:8)(23:4) (36:16)(36:19) wiggle (34:25) willing (34:5)(41:10) winstead (1:15)(3:19)</p>	<p>(42:18) wish (6:2)(35:14)(42:23) wishes (41:23) wishing (6:10)(7:1) within (27:1)(35:18) without (16:11) witness (21:24)(27:25) wondering (34:12) words (22:24) work (13:17) writing (5:16) written (5:8)(5:13) (7:13)(7:23)(8:17)(9:5) (9:8)(14:8)(21:22)(37:1) wrong (17:9) wrote (36:24)</p> <hr/> <p style="text-align: center;">Y</p> <p>years (10:19)(10:21) (11:16)(13:14)(13:19) (36:7) yesterday (8:24) yet (30:4) you obviously probably</p>
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September 25, 2018

VIA U.S. MAIL

Malcolm J. Broussard
Executive Director
Louisiana State Board of Pharmacy
3388 Brentwood Drive
Baton Rouge, LA 70809-1700

RE: Comment Regarding Proposed Louisiana Uniform Prescription Drug Prior Authorization Form

Dear Mr. Broussard:

We have reviewed the proposed rule and form promulgated by the Louisiana State Board of Pharmacy and Louisiana Board of Medical Examiners as a result of Act 423 of the 2018 Louisiana State Legislature.

We understand the statute allows a health insurance issuer to include issuer-specific information on the form, including but not limited to the issuer's name, address, logo and other contact information. We would like to inquire whether or not issuers may be permitted to utilize their own form as long as it conforms to the regulatory requirements. Alternatively, are issuers permitted to include other fields for physicians to complete when submitting the prior authorization form?

Please feel free to contact me with any questions.

Very truly yours,

Elisa Y. Muller





Louisiana Board of Pharmacy

3388 Brentwood Drive
Baton Rouge, Louisiana 70809-1700
Telephone 225.925.6496 ~ E-mail: info@pharmacy.la.gov



October 22, 2018

Elisa Y. Muller
Quarles & Brady, LLP
300 N LaSalle St Ste 4000
Chicago, IL 60654-3406

Re: Regulatory Project 2018-2 ~ Louisiana Uniform Prescription Drug Prior Authorization Form

Dear Ms. Muller:

Thank you for your interest in the Board's proposed rule relative to prior authorization forms. You did not request any amendments to the proposed rule but you did pose the following questions:

We would like to inquire whether or not issuers may be permitted to utilize their own form as long as it conforms to the regulatory requirements? Alternatively, are issuers permitted to include other fields for physicians to complete when submitting the prior authorization form?

The Board has interpreted the enabling legislation (Act 423 of 2018 Legislature) to require the use of the form jointly promulgated by the medical and pharmacy boards, subject to the two exclusions identified in the legislation (specialty medications and medications electronically prescribed). The requirement to use the form promulgated by the boards would seem to exclude any other forms. With that said, the proposed rule requires the use of the form developed and promulgated by the boards, either in written form or its electronic equivalent.

The legislation specifies the form shall not exceed two pages in length, excluding any instructions or guiding information. Further, the statute permits the insurance issuer to include issuer specific information on the form including the issuer's name, address, logo and other contact information for the issuer. The Board has interpreted the legislation to exclude the placement of any other data fields on the form not contained within the form promulgated by the two boards.

We trust this information is responsive to your request for guidance. The Board has determined no revisions to the proposed rule are necessary. We will submit the required report to the Joint Legislative Oversight Committee on Health and Welfare with our recommendation to publish the proposed rule as a Final Rule in the Louisiana Register with an effective date of January 1, 2019.

For the Board:

Malcolm J Broussard
Executive Director

NOTICE: In compliance with Act 2018-655, the Board gives notice to its licensees and applicants of their opportunity to file a complaint about board actions or board procedures. You may submit such complaints to one or more of the following organizations: (1) Louisiana Board of Pharmacy; 3388 Brentwood Dr.; Baton Rouge, LA 70809; 225.925.6496; info@pharmacy.la.gov. (2) Committee on House & Governmental Affairs; La. House of Representatives; PO Box 44486; Baton Rouge, LA 70804; 225.342.2403; h&g@legis.la.gov. (3) Committee on Senate & Governmental Affairs; La. Senate; PO Box 94183; Baton Rouge, LA 70804; 225.342.9845; s&g@legis.la.gov.



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22901 MILLCREEK BLVD, SUITE 240 · HIGHLAND HILLS, OH 44122



September 28, 2018

Malcolm J Broussard
Executive Director
Louisiana Department of Health
Board of Pharmacy
3388 Brentwood Drive
Baton Rouge, LA 70809- 1700

Re: LAC 46:LIII.1129 and 1130 – Uniform Prescription Drug Prior Authorization Form

Dear Executive Director Broussard,

CoverMyMeds appreciates the opportunity to provide comments pertaining to the modification to LAC 46:LIII.1129 and 1130 associated with the adoption of a Uniform Prescription Drug Prior Authorization Form.

As way of background of our experience regarding this topic, CoverMyMeds was formed in 2008 specifically with the vision of improving access for patients to their needed medications by improving the medication prior authorization (PA) process. Presently, we process over 2 million medication prior authorizations monthly, a majority of which are processed electronically utilizing the industry recognized and adopted NCPDP SCRIPT Standard.

Louisiana plans and providers are readily utilizing electronic prior authorization (ePA) as a way to save on both time and costs. Presently, a high percentage of medication PAs are administered via the NCPDP SCRIPT Standard. The real-time ePA process supports the physician so they can best treat the patient, improves the payers speed and efficiency in making coverage determinations, and positively impacts medication adherence by preventing the time-consuming back and forth of the PA process when using paper forms. ePA gives time back to the physician, pharmacist or nurse, which allows them to spend more time with patients and increases speed to therapy through real-time determinations of prescription benefit coverage.

Given the significant benefits of ePA to payers, providers and patients, we would like to ensure that the Uniform Prescription Drug Prior Authorization Form being considered, doesn't negatively impact the utilization of the ePA transactions. While we do not believe the intent was to impact ePA, we would like to confirm that payers and providers can continue to utilize ePA rather than paper forms. This is important as ePA provides a determination in real-time versus the multiple days it can take to receive a response from a faxed form request sent to a payer for review.

The legislation (Senate Bill 29) requiring the Board of Pharmacy and the State Board of Medical Examiners to establish a uniform PA form does state that the adopted form is not required when a medication has been electronically prescribed or when the prescription was written for a specialty medication.

We are looking for guidance from the two boards ensuring the following:

1. If a prescriber, pharmacy, payer are already utilizing ePA to process medication PA's for their patients, they will not need to modify their processes and begin using this form;
2. If the adopted form is utilized for a specialty medication, we would want to ensure that the plan will not have the authority to cease the process and have the prescriber start all over but would be required to continue with the determination process, asking additional questions, etc. as necessary to make that determination;



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3. Many times, the medication prior authorization process is started by the pharmacy (69%), even if the prescription is sent electronically. We ask for clarification that should the prescription be sent via e-Prescribing and the PA process is facilitated by the use of the adopted form, again, the plan will not have the authority to cease the process and have the prescriber start all over.

After reviewing the Uniform Prescription Drug Authorization Form, we have concerns about information that is lacking that could cause confusion and increase the back and forth dialogue between the provider and the plan, increasing the time it would take to get the patient on the medications they need to live healthy lives. The following are our observations and recommendations regarding the proposed form:

- Comments:
 - The provider-administered drugs section wouldn't be necessary since this form is not to be utilized for specialty medications.
 - Since this form is not necessary for use if it is a specialty medication or the prescription was e-prescribed, we suggest placing a message/notation at the top of the form advising the prescriber of these facts.
- Recommendations:
 - Expand the tried and failed section to accommodate more drug history.
 - Create a separate section for non-pharmacologic therapies
 - Add a section/question for expansion of clinical criteria. For example, "Please provide clinical rationale and any additional information pertinent to the request"
 - Add a field for the provider to indicate Urgency of the request.
 - Date of diagnosis, ICD-10 and diagnosis description should be given more area for completion. These can get pretty lengthy.
 - Consider adding a note instructing the provider to attach any relevant documentation that would be helpful to make a determination.

We appreciate the opportunity to submit these comments and questions for your consideration. Should you have any questions or comments regarding the content and points provided, I would be happy to schedule a meeting with you to discuss in greater detail.

Thank you,

Kim Diehl-Boyd
Director of Industry Relations and Government Affairs
CoverMyMeds
(615) 663-5579
kdiehlboyd@covermymeds.com



Louisiana Board of Pharmacy

3388 Brentwood Drive
Baton Rouge, Louisiana 70809-1700
Telephone 225.925.6496 ~ E-mail: info@pharmacy.la.gov



October 22, 2018

Kim Diehl-Boyd
Director, Industry Relations & Government Affairs
CoverMyMeds
kdiehlboyd@covermymeds.com

Re: Regulatory Project 2018-2 ~ Louisiana Uniform Prescription Drug Prior Authorization Form

Dear Ms. Diehl-Boyd:

Thank you for your interest in the Board's proposed rule relative to prior authorization forms. You did not request any amendments to the proposed rule but you did request guidance on three questions and offered comments and recommendations for the Board's consideration.

Guidance Requested

If a prescriber, pharmacy, payer are already utilizing ePA to process medication PA's for their patients, they will not need to modify their processes and begin using this form.

The enabling legislation requires the use of the form jointly promulgated by the medical and pharmacy boards. The proposed rule requires the use of the form promulgated by the board, either in written form or its electronic equivalent. If an entity is using an ePA process and the process is equivalent to the form in the proposed rule, then the entity will not need to modify their process. If their process is not equivalent to the form in the proposed rule, they will need to modify their process to conform to the electronic equivalent of the form promulgated.

If the adopted form is utilized for a specialty medication, we would want to ensure that the plan will not have the authority to cease the process and have the prescriber start all over but would be required to continue with the determination process, asking additional questions, etc. as necessary to make that determination.

While the enabling legislation excludes specialty medications from the requirement to use the form promulgated by the two boards, the legislation did not address the use of prior authorization forms for specialty medications. Without legislative authority, the Board has no basis to regulate the process for prior authorizations for such medications. The legislation identifies the enforcement agencies for the failure to comply with the law – the Louisiana Medicaid program relative to Medicaid managed care organizations and the La. Dept. of Insurance for all other health insurance issuers. You may wish to contact those agencies for their guidance on the scenario you posed.

Many times, the medication prior authorization process is started by the pharmacy (69%), even if the prescription is sent electronically. We ask for clarification that should the prescription be sent via e-prescribing and the PA process is facilitated by the use of the

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adopted form, again, the plan will not have the authority to cease the process and have the prescriber start all over.

While the enabling legislation excludes medications that were electronically prescribed from the requirement to use the form promulgated by the two boards, the legislation did not address the use of prior authorization forms for medications that were electronically prescribed. Without legislative authority, the Board has no basis to regulate the process for prior authorizations for such medications. The legislation identifies the enforcement agencies for the failure to comply with the law – the Louisiana Medicaid program relative to Medicaid managed care organizations and the La. Dept. of Insurance for all other health insurance issuers. You may wish to contact those agencies for their guidance on the scenario you posed.

Comments

The provider-administered drugs section wouldn't be necessary since this form is not to be used for specialty medications.

There are many physician-administered drugs that are not specialty medications, and the Board has determined this data field is necessary.

Since this form is not necessary for use if it is a specialty medication or the prescription was e-prescribed, we suggest placing a message/notation at the top of the form advising the prescriber of those facts.

The enabling legislation allows the appendage of instructions or guidance information to the form. The Board believes that document is the best place to communicate such exclusionary information to the prescriber.

Recommendations

Expand the tried and failed section to accommodate more drug history.

The enabling legislation limits the form itself to two pages in length. The stakeholder group composing the form evaluated multiple data elements and determined which items were most relevant in most situations.

Create a separate section for non-pharmacologic therapies.

There is a section for non-pharmacologic therapies. The limit on document size persuaded the document drafters to be efficient in their construction of the data fields.

Add a section/question for expansion of clinical criteria. For example, "Please provide clinical rationale and any additional information pertinent to the request."

The limitation on the size of the document convinced the stakeholder work group to use efficiency in their construction of data fields.

Add a field for the provider to indicate urgency of the request.

The prescribers and dispensers in this state should be aware of the existing rule for pharmacies which authorizes pharmacists to dispense up to a 72-hour supply of a medication while prescriber approval is pending.

Date of diagnosis, ICD-10 and diagnosis description should be given more area for completion. These can get pretty lengthy.

Again, the limitation on the size of the document convinced the stakeholder work group to use efficiency in their construction of data fields.

Consider adding a note instructing the provider to attach any relevant documentation that would be helpful to make a determination.

The Board believes such instructions to the provider are best placed on the accompanying guidance document in lieu of the form itself, which has a legislatively-mandated size limit.

We trust this information is responsive to your request for guidance, comments and recommendations. The Board has determined no revisions to the proposed rule are necessary. We will submit the required report to the Joint Legislative Oversight Committee on Health and Welfare with our recommendation to publish the proposed rule as a Final Rule in the Louisiana Register with an effective date of January 1, 2019.

For the Board:



Malcolm J Broussard
Executive Director

Louisiana Administrative Code

Title 46 – Professional and Occupational Standards

Part LIII – Pharmacists

Chapter 11. Pharmacies

Subchapter B. Pharmacy Records

§1129. Louisiana Uniform Prescription Drug Prior Authorization Form; Requirements; Referral for Enforcement

- A. A prescriber or pharmacy required to obtain prior authorization from a third party payor shall complete the Louisiana Uniform Prescription Drug Prior Authorization Form referenced below in Section 1130, either in written form or its electronic equivalent.
- B. In the event a third party payor demands the completion of an alternative authorization process, the prescriber or pharmacy shall refer the demand to the appropriate enforcement agency.
 - 1. If the demand is made by a Medicaid managed care organization, the prescriber or pharmacy shall refer the demand to the Dept. of Health.
 - 2. If the demand is made by any other third party payor, the prescriber or pharmacy shall refer the demand to the Dept. of Insurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1006.1(C) and 46:460.33(B).

HISTORICAL NOTE: Promulgated by the Department of Health, Board of Pharmacy, LR

§1130. Louisiana Uniform Prescription Drug Prior Authorization Form

[Form begins top of next page]

LOUISIANA UNIFORM PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

SECTION I — SUBMISSION

Submitted to:	Phone:	Fax:	Date:
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SECTION II — PRESCRIBER INFORMATION

Last Name, First Name MI:		NPI# or Plan Provider #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION III — PATIENT INFORMATION

Last Name, First Name MI:		DOB:	Phone:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
				<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
Address:		City:	State:	ZIP Code:	
Plan Name (if different from Section I):	Member or Medicaid ID #:	Plan Provider ID:			
Patient is currently a hospital inpatient getting ready for discharge? ___ Yes ___ No Date of Discharge: _____					
Patient is being discharged from a psychiatric facility? ___ Yes ___ No Date of Discharge: _____					
Patient is being discharged from a residential substance use facility? ___ Yes ___ No Date of Discharge: _____					
Patient is a long-term care resident? ___ Yes ___ No If yes, name and phone number: _____					
EPSTD Support Coordinator contact information, if applicable: _____					

SECTION IV — PRESCRIPTION DRUG INFORMATION

Requested Drug Name:						
Strength:	Dosage Form:	Route of Admin:	Quantity:	Days' Supply:	Dosage Interval/Directions for Use:	Expected Therapy Duration/Start Date:
To the best of your knowledge this medication is: ___ New therapy/Initial request ___ Continuation of therapy/Reauthorization request						
For Provider Administered Drugs only:						
HCPCS/CPT-4 Code: _____ NDC#: _____ Dose Per Administration: _____						
Other Codes: _____						
Will patient receive the drug in the physician's office? ___ Yes ___ No – If no, list name and NPI of servicing provider/facility: _____						

SECTION V — PATIENT CLINICAL INFORMATION

Primary diagnosis relevant to this request:		ICD-10 Diagnosis Code:	Date Diagnosed:
Secondary diagnosis relevant to this request:		ICD-10 Diagnosis Code:	Date Diagnosed:
For pain-related diagnoses, pain is: ___ Acute ___ Chronic			
For postoperative pain-related diagnoses: Date of Surgery _____			
Pertinent laboratory values and dates (attach or list below):			
Date	Name of Test	Value	

SECTION VI - This Section For Opioid Medications Only

Does the quantity requested exceed the max quantity limit allowed? ___Yes ___No (If yes, provide justification below.)

Cumulative daily MME_____

Does cumulative daily MME exceed the daily max MME allowed? ___Yes ___No (If yes, provide justification below.)

SHORT AND LONG-ACTING OPIOIDS	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
			B. The patient has been screened for substance abuse / opioid dependence . <i>(Not required for recipients in long-term care facility.)</i>
			C. The PMP will be accessed each time a controlled prescription is written for this patient.
			D. A treatment plan which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			E. Criteria for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			F. Benefits and potential harms of opioid use have been discussed with this patient.
			G. An Opioid Treatment Agreement signed by both the patient and prescriber is on file. <i>(Not required for recipients in long-term care facility.)</i>
LONG-ACTING OPIOIDS			H. The patient requires continuous around the clock analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			I. Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in pharmacologic/non-pharmacologic treatment section below.
			J. Medication has not been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			K. Medication has not been prescribed for use as an as-needed (PRN) analgesic.
			L. Prescribing information for requested product has been thoroughly reviewed by prescriber.

IF NO FOR ANY OF THE ABOVE (A-L), PLEASE EXPLAIN:

SECTION VII - Pharmacologic & non-pharmacologic treatment(s) used for this diagnosis (both previous & current):

Drug name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason

Drug Allergies: _____ Height (if applicable): _____ Weight (if applicable): _____

Is there clinical evidence or patient history that suggests the use of the plan's pre-requisite medication(s), e.g. step medications, will be ineffective or cause an adverse reaction to the patient? ___Yes ___No (If yes, please explain in Section VIII below.)

SECTION VIII — JUSTIFICATION (SEE INSTRUCTIONS)

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request, if applicable.

Signature of Prescriber: _____

Date: _____

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1006.1(C) and 46:460.33(B).
HISTORICAL NOTE: Promulgated by the Department of Health, Board of Pharmacy, LR