Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Long-Acting Injectable Antipsychotics

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient over the age of 18?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of schizophrenia, schizoaffective disorder (only if requested medication is Invega Sustenna) or bipolar disorder (only if requested medication is Risperdal Consta or Abilify Maintena)?

☐ Yes ☐ No

Q3. Has the patient been started and stabilized on treatment with the requested long acting injectable antipsychotic? Please provide documentation with date of last injection.

☐ Yes ☐ No

Q4. Is this request for Invega Trinza?

☐ Yes ☐ No

Q5. Has the patient been stabilized on Invega Sustenna (78 mg, 117 mg, 156 mg, or 234 mg) for at least 4 months and receiving the same dose for at least the last two doses?

☐ Yes ☐ No

Q6. Is the request for Risperdal Consta, Invega Sustenna, or Abilify Maintena OR has the patient failed treatment with the listed preferred alternatives? Please attach documentation of failure to preferred injectable antipsychotics with dates of trial.

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q7. Has the patient tolerated treatment with oral aripiprazole, oral risperidone, or oral ziprasidone (based on requested injectable antipsychotic) without side effects?	
☐ Yes	☐ No
Q8. Has the patient had repeat relapses (e.g. hospital admissions) related to diagnosis? Please indicate dates and duration.	
☐ Yes	☐ No
Q9. Does the patient have a history of long-term non-compliance with oral antipsychotic medication and/or a documented medical reason which would prevent the patient from using oral formulary atypical antipsychotic medication?	
☐ Yes	☐ No
Q10. Has the patient failed measures (such as providing patient with instructions and problem-solving strategies such as reminders, self-monitoring tools, cues, and reinforcements) to improve compliance with formulary oral medications? Please document which adherence measures were done to improve compliance.	
☐ Yes	☐ No
Q11. Requested Duration:	
☐ 12 Months	
Q12. Additional Information:	

Prescriber Signature _____ Date _____

Updated 2018

Sunray
Specialty Pharmacy
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