



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

Long-Acting Injectable Antipsychotics Renewal

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: <input type="checkbox"/> Medicaid	City, State ZIP: _____
<input type="checkbox"/> CHIP	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. Has the patient been previously approved for this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q2. Has the patient been compliant with filling their prescription for the long acting injectable antipsychotic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q3. Has greater than the recommended length of time elapsed since the patient's last injection with requested injectable antipsychotic? Please provide date of last injection. <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. Has documentation been attached indicating the reason why the patient missed doses and treatment plan to restart therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Has the patient clinically improved or remained stable while receiving? Please submit documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. Has the patient been tolerating the medication? <input type="checkbox"/> Yes <input type="checkbox"/> No

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Patient Name:

Prescriber Name:

Q7. Requested Duration:

12 Months

Q8. Additional Information:

Prescriber Signature

Date

Updated 2018



Phone: 215-471-4000 x0 | Fax: 215-471-4001