Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐Medicaid ☐CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
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 this a request for a preferred antipsychotic drug (e.g., Abilify Maintena, aripiprazole tablet, Aristada, Aristada Initio, clozapine tablet, fluphenazine tablet, fluphenazine decanoate injection, Haldol 5 mg ampule, haloperidol tablet, haloperidol decanoate injection, haloperidol lactate injection, haloperidol lactate oral concentrate, Invega Sustenna, Invega Trinza, loxapine capsule, olanzapine tablet, perphenazine tablet, Perseris, quetiapine extended-release, quetiapine immediate-release, Risperdal Consta, risperidone tablet, risperidone oral solution, trifluoperazine tablet, ziprasidone capsule, Zyprexa Relprevv)?

☐ Yes ☐ No

Q2. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of (such as, but not limited to, diabetes, obesity, etc.) the preferred antipsychotics (e.g., Abilify Maintena, aripiprazole tablet, Aristada, Aristada Initio, clozapine tablet, fluphenazine tablet, fluphenazine decanoate injection, Haldol 5 mg ampule, haloperidol tablet, haloperidol decanoate injection, haloperidol lactate injection, haloperidol lactate oral concentrate, Invega Sustenna, Invega Trinza, loxapine capsule, olanzapine tablet, perphenazine tablet, Perseris, quetiapine extended-release, quetiapine immediate-release, Risperdal Consta, risperidone tablet, risperidone oral solution, trifluoperazine tablet, ziprasidone capsule, Zyprexa Relprevv)?

☐ Yes ☐ No

Q3. Does the patient have a current history (within the past 90 days) of being prescribed the requested non-preferred antipsychotic drug?

☐ Yes ☐ No

Q4. Is this a request for Invega (paliperidone extended-release)?

☐ Yes ☐ No

Q5. Does the patient have active liver disease with elevated liver function tests (LFTs) OR is the patient at risk for

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:

active liver disease?

☐ Yes ☐ No

Q6. Is this a request for a typical or atypical antipsychotic when there is a record of a recent paid claim within the same therapeutic class of drugs (i.e., therapeutic duplication)?

☐ Yes ☐ No

Q7. Is the patient being titrated to, or tapered from, another drug in the same class?

☐ Yes ☐ No

Q8. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q10. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q11. Does the patient have documentation of ALL of the following: A) improvement in target symptoms, B) monitoring of weight or body mass index (BMI) quarterly, C) monitoring of blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS) after the first three months of therapy and then annually, D) plan for taper or discontinuation of the antipsychotic OR rationale for continued use?

☐ Yes ☐ No

Q12. Does the patient have severe behavioral problems related to psychotic or neuro-developmental disorders [such as those seen in, but not limited to, the following diagnoses: autism spectrum disorder, intellectual disability, conduct disorder, bipolar disease, tic disorder (including Tourette's syndrome), transient encephalopathy, schizophrenia]?

☐ Yes ☐ No

Q13. Is the patient 14 years of age or older?

☐ Yes ☐ No

Q14. Is the requested drug being prescribed by or in consultation with ONE of the following: A) pediatric neurologist, B) child and adolescent psychiatrist, C) child development pediatrician, D) general psychiatrist?

☐ Yes ☐ No

Q15. Does the patient have chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies (such as, but not limited to, evidence-based behavioral, cognitive, and family based therapies)?

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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:

☐ Yes ☐ No

Q16. Does the patient have documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)?

☐ Yes ☐ No

Q17. Is the patient using a low dose oral atypical antipsychotic [defined as less than or equal to the following doses per day: 10 mg of Abilify (aripiprazole), 100 mg of Clozaril (clozapine) or Fazaclo (clozapine), 2 mg of Fanapt (iloperidone), 40 mg of Geodon (ziprasidone), 3 mg of Invega (paliperidone), 20 mg of Latuda (lurasidone), 1 mg of Risperdal (risperidone), 0.5 mg of Rexulti (brexpiprazole), 5 mg of Saphris (asenapine), 3 mg/25 mg Symbyax (olanzapine/fluoxetine), 150 mg of Seroquel (quetiapine) or Seroquel XR (quetiapine extended-release), 50 mg of Versacloz (clozapine), 5 mg of Zyprexa (olanzapine)]?

☐ Yes ☐ No

Q18. Does the patient have a diagnosis that is indicated in the package insert OR is listed in nationally recognized compendia for the determination of medically accepted indications for off-label uses?

☐ Yes ☐ No

Q19. Additional Information:

Q20. Is the requested drug being prescribed by or in consultation with ONE of the following: A) pediatric neurologist, B) child and adolescent psychiatrist, C) child development pediatrician?

☐ Yes ☐ No

Prescriber Signature _____ Date _____

Updated for 2020