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?

☐ 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?

☐ Yes ☐ No

Q3. Does the patient have a current history (within the past 90 days) of being prescribed the requested non-preferred antipsychotic drug? Does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred.

☐ Yes ☐ No

Q4. 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

Q5. Is the patient being titrated to, or tapered from, another drug in the same class?

☐ Yes ☐ No

Q6. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

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☐ Yes ☐ No

Q8. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q9. 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 or hemoglobin A1c, 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

Q10. 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, mood disorders with psychotic features, tic disorder (including Tourette's syndrome), transient encephalopathy, schizophrenia and schizophrenia related disorders]?

☐ Yes ☐ No

Q11. Is the patient 14 years of age or older?

☐ Yes ☐ No

Q12. 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

Q13. Does the patient have chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies (e.g., evidence-based behavioral, cognitive, and family based therapies) when indicated according to national treatment guidelines?

☐ Yes ☐ No

Q14. Does the patient have documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose or hemoglobin A1c, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)?

☐ Yes ☐ No

Q15. 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

Q16. Additional Information:

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Patient Name:	Prescriber Name:

Prescriber Signature

Date

Updated for 2023