Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Skeletal Muscle Relaxants

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 skeletal muscle relaxant that is subject to the Drug Enforcement Agency (DEA) Controlled Substances Act (CSA) (i.e., a controlled substance)?

☐ Yes ☐ No

Q2. Is there documentation that the prescriber or prescriber's delegate has conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the patient's controlled substance prescription history?

☐ Yes ☐ No

Q3. Is this a request for a skeletal muscle relaxant for a patient with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder?

☐ Yes ☐ No

Q4. Are the buprenorphine agent and the skeletal muscle relaxant prescribed by the same prescriber?

☐ Yes ☐ No

Q5. Are the prescribers of the buprenorphine agent and the skeletal muscle relaxant aware of the other prescription(s)?

☐ Yes ☐ No

Q6. Does the patient have an acute need for therapy with the skeletal muscle relaxant?

☐ Yes ☐ No

Q7. Is this a request for a skeletal muscle relaxant when there is a recent paid claim for another skeletal muscle relaxant (i.e., potential therapeutic duplication)?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Is the patient being titrated to or tapered from a drug in the same class?	
☐ Yes	☐ No
Q9. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?	
☐ Yes	☐ No
Q10. Is this a request for a preferred skeletal muscle relaxant?	
☐ Yes	☐ No
Q11. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred skeletal muscle relaxants approved or medically accepted for the patient's diagnosis?	
☐ Yes	☐ No
Q12. Additional Information:	

_____ _____

Prescriber Signature Date

Updated for 2023