Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Alzheimer's Agents

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. Does the patient have a history of therapeutic failure, a contraindication to, or intolerance of the preferred Alzheimer's Agents (e.g., donepezil ODT, donepezil 5 mg or 10 mg tablet, galantamine tablet, galantamine ER capsule, memantine tablet, rivastigmine capsule)?

☐ Yes ☐ No

Q2. Is this a request for an acetylcholinesterase inhibitor when the patient has a recent paid claim for an acetylcholinesterase inhibitor (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q3. For therapeutic duplication, is the patient being titrated to or tapered from another acetylcholinesterase inhibitor Alzheimer's Agent?

☐ Yes ☐ No

Q4. Additional Information:

Prescriber Signature

Date

Updated for 2023

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