



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Analgesics - Non-Opioid Barbituate
Combinations

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, 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 the requested drug being prescribed for an indication that is included in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes checkbox

No checkbox

Q2. Is the requested drug age-appropriate for the patient according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q3. Is the patient 65 years of age or older?

Yes checkbox

No checkbox

Q4. Has the patient received a risk assessment by the prescriber AND is there documentation of prescriber counseling regarding the potential increased risks of the requested drug?

Yes checkbox

No checkbox

Q5. Does the prescriber indicate that the benefits of the requested drug outweigh the risks for the patient?

Yes checkbox

No checkbox

Q6. Is there documentation of prescriber counseling regarding the potential increased risks of the requested drug?

Yes checkbox

No checkbox

Q7. Is the patient taking primidone or other medication(s) containing a barbiturate?



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Patient Name:	Prescriber Name:
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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Will the patient be taking the requested drug more than three (3) days per month?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Does the patient have a diagnosis of headache based on the most current International Headache Society Classification of Headache Disorders?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Does the patient have a documented history of trial and failure of, intolerance of, or contraindication to standard abortive medication based on headache classification as recommended by the most recent American Academy of Neurology, American Academy of Family Physicians, World Health Organization, or the European Academy of Neurology treatment guidelines?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Is the patient being treated for chronic daily headache, defined as the presence of headache on 15 days or more per month for at least three (3) months?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Does the patient have documentation of results of a physical examination and complete neurological examination to rule out secondary causes of headache?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Does the patient have documentation of an evaluation for the overuse of abortive medications, including but not limited to acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), triptans, butalbital, caffeine, and opioids?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Does the patient have documentation of prescriber counseling regarding behavioral modifications such as cessation of caffeine and tobacco use, improved sleep hygiene, diet changes, and regular mealtimes?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Is the patient taking preventive drug therapy based on headache classification as recommended by the most recent American Academy of Neurology, American Academy of Family Physicians, World Health Organization, or European Academy of Neurology treatment guidelines?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Patient Name: Prescriber Name:

Q17. Does the patient have a contraindication to or intolerance of standard preventive drug therapies?
Q18. Does the patient have documentation of prescriber counseling regarding the potential adverse effects of the requested drug...
Q19. Does the patient have a history of substance use disorder?
Q20. Does the patient have results of a recent urine drug screen (UDS) testing for licit and illicit drugs...
Q21. Is the patient being treated by a prescribing provider who confirms that he or she, or the prescribing provider's delegate, conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP)...
Q22. Is this a request for a preferred drug?
Q23. Does the patient have a documented history of therapeutic failure, a contraindication to, or intolerance of the preferred agents?
Q24. Additional Information:

Prescriber Signature

Date

Updated for 2023