



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Antidepressants - SSRIs

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, etc.

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 selective serotonin reuptake inhibitor (SSRI) antidepressant?

Yes checkbox

No checkbox

Q2. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred selective serotonin reuptake inhibitor (SSRI) antidepressants?

Yes checkbox

No checkbox

Q3. Does the patient have a current history (within the past 90 days) of being prescribed the requested non-preferred selective serotonin reuptake inhibitor (SSRI) antidepressant?

Yes checkbox

No checkbox

Q4. Is this a request for a selective serotonin reuptake inhibitor (SSRI) antidepressant when the patient has a recent claim for a selective serotonin reuptake inhibitor (SSRI) antidepressant (i.e., potential therapeutic duplication)?

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q7. Additional Information:

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party.



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Patient Name:	Prescriber Name:
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Prescriber Signature

Date

Updated for 2023