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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member 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. The request is for renewal of the Antipsychotic for a child under 18 years of age that was previously approved. If YES, go to 13. If NO, go to 2.

☐ Yes ☐ No

Q2. The request is for a non-preferred Antipsychotic, and the member has a history of therapeutic failure of or a contraindication or an intolerance (such as, but not limited to, diabetes, obesity, etc.) to the preferred Antipsychotics approved or medically accepted for the beneficiary's diagnosis or indication. If YES, go to 4. If NO or Not Applicable, go to 3.

☐ Yes ☐ No ☐ NA

Q3. The member has a current history (within the past 90 days) of being prescribed the same non-preferred Antipsychotic (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. The request is for Opipza (aripiprazole) film, and the member has a contraindication or an intolerance to aripiprazole ODT that would not be expected to occur with Opipza (aripiprazole) film.

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☐ Yes ☐ No ☐ NA

Q5. The request is for an Antipsychotic for a child under the age of 18 years.

☐ Yes ☐ No

Q6. The member is age-appropriate according to U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q7. The member has severe symptoms related to psychotic or neuro-developmental disorders such as seen in, but not limited to, the following diagnoses:

a. Autism spectrum disorder,
b. Intellectual disability,
c. Conduct disorder,
d. Bipolar disorder,
e. Mood disorders with psychotic features,
f. Tic disorder, including Tourette's syndrome,
g. Transient encephalopathy,
h. Schizophrenia and schizophrenia-related disorders,

☐ Yes ☐ No

Q8. The member has chart documented evidence of a comprehensive evaluation.

☐ Yes ☐ No

Q9. The member has a documented plan of care that includes non-pharmacologic therapies (e.g., evidence-based behavioral, cognitive, and family based therapies) when indicated according to national treatment guidelines.

☐ Yes ☐ No

Q10. For an Antipsychotic with risk of metabolic changes, has documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose or hemoglobin A1c, fasting

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lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS).

☐ Yes ☐ No

Q11. If under 14 years of age, is prescribed the drug by or in consultation with one of the following: Pediatric neurologist, Child and adolescent psychiatrist, Child development pediatrician.

☐ Yes ☐ No ☐ NA

Q12. If 14 years of age or older, is prescribed the drug by or in consultation with one of the following: Pediatric neurologist, Child and adolescent psychiatrist, Child development pediatrician, General psychiatrist.

☐ Yes ☐ No

Q13. The member has documented improvement in target symptoms.

☐ Yes ☐ No

Q14. For an Antipsychotic with risk of metabolic changes, both of the following:

☐ Documented monitoring of weight or BMI quarterly

☐ Documented monitoring of blood pressure, fasting glucose or hemoglobin A1c, fasting lipid panel, and EPS using AIMS after the first three months of therapy and then annually.

Q15. A documented plan is attached for taper/discontinuation of the Antipsychotic or there is rationale for continued use.

☐ Yes ☐ No

Q16. For a non-preferred Antipsychotic with a therapeutically equivalent brand or generic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested drug.

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q17. Additional Information:

Prescriber Signature

Date

v2026