HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Apomorphine - Non-PDL

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. Is this a renewal request? If YES, go to 8. If NO, go to 2.

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of advanced Parkinson's Disease (PD) with documented hypomobility "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes)? (documentation must be attached).

☐ Yes ☐ No

Q3. Is the medication being prescribed by or in consultation with a specialist (who specializes in the treatment of PD or a neurologist)?

☐ Yes ☐ No

Q4. Is there documentation of an inadequate response, intolerance, or contraindication to conventional oral therapies (such as carbidopa-levodopa, pramipexole, ropinirole, bromocriptine, amantadine, selegiline, trihexyphenidyl, benztropine, entacapone, tolcapone)? (documentation must be attached).

☐ Yes ☐ No

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Apomorphine - Non-PDL

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:

Q5. Is the medication being prescribed and administered in accordance with FDA-approved package labeling?

☐ Yes ☐ No

Q6. Has the patient been counseled on the risks of using alcohol, antihypertensive medications, and vasodilating medications while taking this medication?

☐ Yes ☐ No

Q7. Is the treatment plan attached showing how the medication will be administered, duration of therapy, and other medications that will be continued?

☐ Yes ☐ No

Q8. Does the patient continue to need apomorphine and meet the criteria identified for initial approval?

☐ Yes ☐ No

Q9. Does the patient tolerate the medication without significant or serious side effects? (must attach documentation)

☐ Yes ☐ No

Q10. Has the patient had an improvement in symptoms from baseline? (must attach documentation)

☐ Yes ☐ No

Q11. Requested Duration:

☐ 12 Months ☐ Other:

Q12. Additional Information:

Prescriber Signature Date

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Apomorphine - Non-PDL

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:

v2026