



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

Narcotic Analgesics

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: HPP Member Number: Date of Birth: Address: City, State ZIP: Patient Primary Phone: Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Prescriber Name: Fax: _____ Phone: _____ Office Contact: NPI: _____ Promise ID: _____ <i>Prescriber PA PROMISE ID:</i> Address: City, State ZIP: Specialty/facility name (if applicable):
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Expedited/Urgent

Drug Name:

Strength:

Days Supply:

Number of Refills:

Directions / SIG:

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. Narcotic Type: <input type="checkbox"/> Long Acting (such as) <input type="checkbox"/> Short Acting (such as)	
Q2. Members Age: <input type="checkbox"/> Age 21 or older for greater than a 5 day supply or if there is paid claim within the past 180 days <input type="checkbox"/> Under 21 for greater than a 3 day supply or if there is a paid claim within the past 180 days	
Q3. Is the diagnosis cancer, sickle cell or is the patient in palliative/hospice care, AND prescription is within quantity limits (limit of 90MME/day)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q4. If under 21, does the short acting product contain codeine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q5. Is there documentation of failure, intolerance, or contraindication to non-pharmacologic treatment (if applicable to diagnosis)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Is there documentation of failure, intolerance, or contraindication to non-opioid analgesics (acetaminophen, NSAIDS)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Patient Name:

Prescriber Name:

Q7. For Long-Acting: Has the patient tried and failed a short-acting narcotic analgesic?

Yes

No

N/A

Q8. Are chart notes provided documenting the diagnosis including documentation of symptoms, imaging, or other testing which supports the diagnosis?

Yes

No

Q9. Is there documentation of severe pain documented by a pain assessment tool (please provide documentation)?

Yes

No

Q10. Is the diagnosis neuropathic pain or migraine headaches?

Yes

No

Q11. Is there documentation showing first line medications for neuropathic pain or migraine headaches have been tried?

Yes

No

Q12. Is there documentation of the duration of treatment and the treatment plan?

Yes

No

Q13. Is the dose appropriate based on the FDA approved dosage guidelines or nationally recognized compendia for off-label use?

Yes

No

Q14. If patient is 21 or over, was evaluation for potential misuse and abuse completed including family and social history?

Yes

No

Q15. If the patient is 21 or over, is there documentation that the patient has been counseled regarding the risk of addiction, abuse, and misuse?

Yes

No

Q16. If patient is under 21, is there documentation that the recipient and guardian have been counseled regarding the risk of addiction, abuse, and misuse?

Yes

No

N/A - 21 or over

Q17. Has the provider checked the PDMP (Pennsylvania Prescription Drug Monitoring Program) before prescribing the medication?

Yes

No

Q18. Was a urine drug screen completed (include most recent date) and consistent with prescribed medications and

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Patient Name:

Prescriber Name:

negative for non-prescribed controlled and illicit substances?

Yes

No

Q19. Will the member be taking a combination of benzodiazepine and narcotic analgesic, or is the member currently taking a combination of benzodiazepine and narcotic analgesic?

Yes

No

Q20. Is there documentation of a taper plan in place to decrease the dose of either medication (taper plan can be for tapering one medication at a time) to the minimum possible dose needed to achieve the desired effect ?

Yes

No

Q21. Are factors present which increase the risk for opioid related harm (such as history of substance use disorder, opioid doses greater than or equal to 50 morphine milligram equivalents, concurrent benzodiazepine use)?

Yes

No

Q22. Did the prescriber offer a prescription for naloxone to the member?

Yes

No

Q23. Is the request for a formulary medication?

Yes

No

Q24. If the member does not meet the criteria from the guidelines above, is the member currently on chronic opioid therapy?

Yes

No

Q25. Is there documentation of a tapering plan including duration of treatment?

Yes

No

Q26. Requested duration:

1 month

3 months

6 months

Q27. Additional Information:

Prescriber Signature

Date

Updated 2018