Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

VMAT2 INHIBITORS

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:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: **Specialty/facility name (if applicable):**	

□ 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. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q2. Is the medication being prescribed by a neurologist, psychiatrist, or a movement disorder specialist provided the patient has reasonable access?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis consistent with Food and Drug Administration (FDA) approved indications for the drug (Tardive Dyskinesia [TD] for Ingrezza; TD or Chorea associated with Huntington's disease for Austedo; or Chorea associated with Huntington's disease for Xenazine)?

☐ Yes ☐ No

Q4. For a diagnosis of Tardive Dyskinesia: Has the patient been evaluated for other movement disorder? (Please attach medical records including an evaluation to rule out other movement disorder diagnoses such as Chorea associated with Huntington's disease, or Parkinson's disease).

☐ Yes ☐ No

Q5. Are chart notes confirming that the patient has a diagnosis of Tardive Dyskinesia attached? (Please attach the details of the patient's symptoms including when symptoms first began).

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Has documentation of the patient's recent Abnormal Involuntary Movement Scale (AIMS) been attached? (Please attach documentation of the patient's recent AIMS.)

☐ Yes ☐ No

Q7. Has documentation of the patient's baseline Abnormal Involuntary Movement Scale (AIMS) been attached to compare to the recent AIMS, in order to attribute the patient's Tardive Dyskinesia diagnosis to the use of a dopamine-receptor blocking agent(s)? (Please attach documentation of the patient's baseline AIMS.)

☐ Yes ☐ No

Q8. Has documentation been attached, or is claims history present, showing that the patient has current or former chronic use of a dopamine-receptor blocking agent(s)?

☐ Yes ☐ No

Q9. Has documentation been attached indicating that dose reduction of the dopamine-receptor blocking agent(s), gradual discontinuation of the dopamine-receptor blocking agent(s), or switching from a typical to an atypical dopamine-receptor blocking agent(s) is not an option?

☐ Yes ☐ No

Q10. Has the patient tried alternative medication (amantadine) if applicable? Please attach medical records confirming the reason why alternative medication (amantadine) cannot be tried or documentation of medication(s) tried, with dose, dates/duration of use, and specific outcomes.)

☐ Yes ☐ No

Q11. For a diagnosis of Chorea associated with Huntington's disease: Has the patient been evaluated for other movement disorder? (Please attach medical records including an evaluation to rule out other movement disorder diagnoses such as Tardive Dyskinesia, or Parkinson's disease).

☐ Yes ☐ No

Q12. Are chart notes confirming that the patient has a diagnosis of Chorea associated with Huntington's disease attached? (Please attach the details of the patient's symptoms including when symptoms first began).

☐ Yes ☐ No

Q13. Is the patient currently taking a strong CYP2D6 Inhibitors (including paroxetine, fluoxetine, quinidine)?

☐ Yes ☐ No

Q14. Austedo or Xenazine in combination with a strong CYP2D6 inhibitor:

☐ For Austedo: Is the maximum daily dose less than or equal to 36 mg a day or 18 mg per single dose when co-administered with a strong CYP2D6 inhibitor?

☐ For Xenazine: Is the maximum daily dose less than or equal to 50 mg a day or 25 mg per single dose when co-administered with a strong CYP2D6 inhibitor?

Q15. Is the patient currently taking a Monoamine Oxidase Inhibitor (such as isocarboxazid, phenelzine, selegiline)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q16. Does the patient have congenital QT syndrome or arrhythmias associated with a prolonged QT interval or currently taking a drug known to prolong the QT interval (such as chlorpromazine, haloperidol, thioridazine, ziprasidone, moxifloxacin, Class 1A antiarrhythmic medications [quinidine, procainamide] and Class III antiarrhythmic medications [amiodarone, sotalol])? (Please attach documentation showing that the patient has been evaluated for cardiac abnormalities).

☐ Yes ☐ No

Q17. Requested Duration:

☐ 3 Months

Q18. Additional Information:

Prescriber Signature

Date

Updated 2018