HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

VMAT2 INHIBITORS Renewal

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. Has the patient been previously approved for the requested medication?
☐ Yes ☐ No

Q2. Has the patient been compliant with receiving the requested medication?
☐ Yes ☐ No

Q3. Is the requested medication Ingrezza or Austedo for the treatment of Tardive Dyskinesia?
☐ Yes ☐ No

Q4. Has documentation of improvement in Tardive Dyskinesia symptoms as evidenced by a reduction in the updated AIMS score after treatment with Ingrezza or Austedo, compared to the AIMS score prior to treatment with Ingrezza or Austedo, been attached? (Please attach an updated AIMS score that was completed after Ingrezza or Austedo was started.)
☐ Yes ☐ No

Q5. Has documentation of improvement in Chorea symptoms after treatment with Austedo or Xenazine been attached?
☐ Yes ☐ No

Q6. Has the patient been tolerating the requested medication without any significant side effects? (Please attach documentation that the member has been evaluated for any side effects related to treatment with requested

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medication)

☐ Yes ☐ No

Q7. Is the patient currently taking a Monoamine Oxidase Inhibitor (such as isocarboxazid, phenelzine, selegiline)?

☐ Yes ☐ No

Q8. 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

Q9. Requested Duration:

☐ 6 Months

Q10. Additional Information:

Prescriber Signature

Date

Updated 2018

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