



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

MIGRAINE PREVENTION AGENTS (CALCITONIN GENE-RELATE)

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.

Form with fields for Patient Name, HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Prescriber Name, Fax, Phone, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, 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 18 years of age or older?

Yes checkbox

No checkbox

Q2. Does the patient have a diagnosis of migraine?

Yes checkbox

No checkbox

Q3. Is the medication being prescribed by or in consultation with a neurologist or headache specialist?

Yes checkbox

No checkbox

Q4. Has the diagnosis been confirmed based on the most current criteria from the International Classification of Headache Disorders?

Yes checkbox

No checkbox

Q5. Did the patient have 4 or more migraine days per month or headaches that lasted longer than 12 hours within the past 3 months? (Please provide documentation showing the number of monthly migraine headache days)

Yes checkbox

No checkbox

Q6. Has the patient tried and failed at least two formulary alternatives from different drug classes (such as Beta Blockers, Antidepressants, Anticonvulsants)? Please include documentation of agents used with doses, date/duration of use and specific outcomes or documentation of intolerance or contraindication to trying at least 2 formulary

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

**MIGRAINE PREVENTION AGENTS (CALCITONIN GENE-
RELATE**

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:

alternatives.

Yes

No

Q7. For patients diagnosed with chronic migraine experiencing ≥ 15 headache days per month- Has the patient tried treatment with Botox injections? Please include documentation of dose injected (up to 155 units per treatment), date/duration of use and specific outcome or documentation of intolerance or contraindication to treatment with Botox.

Yes

No

Q8. Is the dose prescribed consistent with FDA approved package labeling or nationally recognized compendia?

Yes

No

Q9. Requested Duration:

4 Months

Q10. Additional Information:

Prescriber Signature

Date

Updated 2018