



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

MIGRAINE PREVENTION AGENTS (CALCITONIN GENE-RELATE 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.

Form with two columns: Patient Name and Prescriber Name. Fields include HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Fax, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, and 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 medication?

Yes No

Q2. Has the patient been compliant with filling their prescription?

Yes No

Q3. Has the patient had a positive response to the antimigraine therapy with a reduction in attack frequency, severity and/or duration? Please include documentation of the total number of monthly migraine headache days the patient had over the past 3 months

Yes No

Q4. Is the medication being prescribed by or in consultation with a neurologist or headache specialist?

Yes No

Q5. Is the dose prescribed consistent with FDA approved package labeling or nationally recognized compendia?

Yes No

Q6. Requested Duration:

6 Months

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**Patient Name:**

**Prescriber Name:**

Q7. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated 2018*