Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antipsychotics Under 18

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. Drug name:

- ☐ Abilify
- ☐ Geodon
- ☐ Haldol
- ☐ Risperdal
- ☐ Zyprexa
- ☐ Seroquel
- ☐ Other:_____

Q2. Does the patient have severe behavioral problems related to psychotic or neuro-developmental disorders such as seen in, but not limited to the following diagnoses: autism, intellectual disability, conduct disorder, bipolar disorder, schizophrenia, tic disorder including Tourette's' Syndrome, or transient encephalopathy?

☐ Yes ☐ No

Q3. If the patient is 14 years old or greater, is medication being prescribed by, or in consultation with one of the following specialists: pediatric neurologist, child and adolescent psychiatrist, child development pediatrician, or general psychiatrist)?

☐ Yes ☐ No

Q4. If the patient is less than 14 years old, is medication being prescribed by, or in consultation with one of the following specialists: pediatric neurologist, child and adolescent psychiatrist, or child development pediatrician?

☐ Yes ☐ No

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antipsychotics Under 18

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:**

Q5. Has documentation of comprehensive evaluation including non-pharmacologic therapies (such as behavioral, cognitive, and family based therapies) been completed by prescriber (or in conjunction with specialist)?

☐ Yes ☐ No

Q6. Has documentation of weight, BMI, blood pressure, fasting glucose, and lipid panel been attached?

☐ Yes ☐ No

Q7. Is the medication requested a formulary medication?

☐ Yes ☐ No

Q8. Has the patient been stabilized on the current non-formulary antipsychotic?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 6 months

Q10. Additional Information:

Prescriber Signature

Date

Updated 2018