



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Antipsychotics Under 18 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 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 checkbox

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 documentation of improvement in symptoms been attached?

Yes checkbox

No checkbox

Q2. Has documentation of weight, BMI, blood pressure, fasting glucose, lipid panel, and evaluation of Extrapyridamal symptoms been attached?

Yes checkbox

No checkbox

Q3. Has documentation of treatment plan, including taper/discontinuation plan or rationale for continued use, been attached?

Yes checkbox

No checkbox

Q4. Requested duration:

12 months checkbox

Other: checkbox with blank line

Q5. Additional Information:

Prescriber Signature

Date

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Prescriber Name:

Updated 2018