Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antidepressants

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:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
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 prescribed a dose and frequency that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q2. Does the patient have a history of a contraindication to the prescribed medication?

☐ Yes ☐ No

Q3. Is this a request for Spravato (esketamine)?

☐ Yes ☐ No

Q4. Is Spravato (esketamine) prescribed by or in consultation with a psychiatrist?

☐ Yes ☐ No

Q5. Is Spravato (esketamine) prescribed in conjunction with a therapeutic dose of an oral antidepressant?

☐ Yes ☐ No

Q6. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q7. Does the patient have documentation of improvement in disease severity since initiating treatment?

☐ Yes ☐ No

Q8. Does the patient have a documented diagnosis of treatment-resistant moderate-to-severe major depressive

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Patient Name:	Prescriber Name:

disorder?

☐ Yes ☐ No

Q9. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q10. Is the requested drug being prescribed for the treatment of a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q11. Is the requested drug age-appropriate for the patient according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q12. Does the patient have a documented history of therapeutic failure, intolerance of, or contraindication to the preferred other antidepressant drugs approved or medically accepted for the patient's diagnosis at maximally tolerated doses for a duration of at least six weeks (e.g., amitriptyline, amoxapine, bupropion, bupropion sustained-release, bupropion extended-release, desvenlafaxine succinate extended-release, desvenlafaxine succinate extended-release, doxepin capsule, doxepin oral concentrate, imipramine hydrochloride tablet, mirtazapine tablet, nortriptyline capsule, phenelzine sulfate, trazodone, venlafaxine tablet, venlafaxine extended-release capsule)?

☐ Yes ☐ No

Q13. Does the patient have a documented history of therapeutic failure, intolerance of, or contraindication to selective serotonin reuptake inhibitor (SSRI) antidepressant drugs approved or medically accepted for the patient's diagnosis at maximally tolerated doses for a duration of at least six weeks?

☐ Yes ☐ No

Q14. Does the patient have a current history (within the past 90 days) of being prescribed the requested non-preferred antidepressant drug?

☐ Yes ☐ No

Q15. Additional Information:

Prescriber Signature

Date

Updated for 2020