



Health Partners Plans

**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Skeletal Muscle Relaxants

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 PROMSe ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	
Quantity:	Refills:	
Directions:		
Diagnosis Code:	Diagnosis:	
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>		

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 this a request for a skeletal muscle relaxant that is subject to the Drug Enforcement Agency (DEA) Controlled Substances Act (CSA) (i.e., a controlled substance)?

Yes No

Q2. Is there documentation that the prescriber or prescriber's delegate has conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the patient's controlled substance prescription history?

Yes No

Q3. Is this a request for a skeletal muscle relaxant for a patient with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder?

Yes No

Q4. Are the buprenorphine agent and the skeletal muscle relaxant prescribed by the same prescriber?

Yes No

Q5. Are the prescribers of the buprenorphine agent and the skeletal muscle relaxant aware of the other prescription(s)?

Yes No

Q6. Does the patient have an acute need for therapy with the skeletal muscle relaxant?

Yes No

Q7. Is this a request for a skeletal muscle relaxant when there is a recent paid claim for another skeletal muscle relaxant (i.e., potential therapeutic duplication)?

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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the patient being titrated to or tapered from a drug in the same class?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Is this a request for a preferred skeletal muscle relaxant?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred skeletal muscle relaxants approved or medically accepted for the patient's diagnosis?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Additional Information:	

Prescriber Signature

Date

Updated for 2020