Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Alzheimer's Agents

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 this a request for a renewal of authorization?

☐ Yes ☐ No

Q2. Does the patient have a documented rationale for continuing the requested medication?

☐ Yes ☐ No

Q3. Does the patient's diagnosis meet ANY of the following: A) indicated in the package insert, B) listed in a nationally recognized compendia for the determination of medically-accepted indications for off-label use, C) supported by peer reviewed medical literature provided by the prescriber?

☐ Yes ☐ No

Q4. Is this a request for a preferred Alzheimer's Agent (e.g., donepezil 5 mg and 10 mg tablet, galantamine tablet, memantine tablet, rivastigmine capsule)?

☐ Yes ☐ No

Q5. Does the patient have a history of therapeutic failure, a contraindication to, or intolerance of the preferred Alzheimer's Agents (e.g., donepezil 5 mg and 10 mg tablet, galantamine tablet, memantine tablet, rivastigmine capsule)?

☐ Yes ☐ No

Q6. Is this a request for an acetylcholinesterase inhibitor when the patient has a recent paid claim for an acetylcholinesterase inhibitor (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q7. Is the patient being titrated to, or tapered from, another acetylcholinesterase inhibitor?

☐ Yes ☐ No

Q8. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q9. Additional Information:

Prescriber Signature

Date

Updated for 2020