Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Opioid Dependence Treatment

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

☐ Yes ☐ No

Q2. Is this a request for an oral buprenorphine product that does not contain naloxone?

☐ Yes ☐ No

Q3. Is the prescribed agent being used for induction therapy?

☐ Yes ☐ No

Q4. Is the patient pregnant or breastfeeding?

☐ Yes ☐ No

Q5. Does the patient have a history of contraindication or intolerance to naloxone?

☐ Yes ☐ No

Q6. Is the requested drug a non-preferred oral buprenorphine opioid dependence treatment agent?

☐ Yes ☐ No

Q7. Does the patient have a history of therapeutic failure, contraindication or intolerance to the preferred oral buprenorphine opioid dependence treatments?

☐ Yes ☐ No

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Q8. Is the requested drug a non-preferred alpha2-adrenergic agonist?

☐ Yes ☐ No

Q9. Does the patient have a history of therapeutic failure, contraindication or intolerance to the preferred alpha2-adrenergic agonist opioid dependence treatments?

☐ Yes ☐ No

Q10. Is the requested drug a non-oral buprenorphine opioid dependence treatment?

☐ Yes ☐ No

Q11. Does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred non-oral buprenorphine opioid dependence treatments?

☐ Yes ☐ No

Q12. Has the prescriber or prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program for the patient's controlled substance prescription history? Note: Please attach documentation of this search.

☐ Yes ☐ No

Q13. Is this a request for an oral buprenorphine opioid dependence treatment where the daily dose exceeds 24 mg/day?

☐ Yes ☐ No

Q14. Is the prescribed daily dose consistent with medically accepted prescribing practices and standards of care?

☐ Yes ☐ No

Q15. Is there documentation of an evaluation to determine the recommended level of care?

☐ Yes ☐ No

Q16. Is there documentation of participation in a substance abuse or behavioral health counseling or treatment program or an addictions recovery program?

☐ Yes ☐ No

Q17. Has the patient had a recent urine drug screen for drugs with the potential for abuse?

☐ Yes ☐ No

Q18. For a patient already established on buprenorphine, is there a recent urine drug screen that is positive for buprenorphine and norbuprenorphine?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q19. Additional Information:

Prescriber Signature

Date

Updated for 2021