Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Stimulants and Related 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 renewal of a prior authorization?

☐ Yes ☐ No

Q2. Is this a request for a Stimulant and Related Agent drug when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q3. Is the patient being transitioned to another Stimulants and Related agent with the same duration of action (i.e., short-acting or long-acting) with the intent of discontinuing one of the medications?

☐ Yes ☐ No

Q4. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q5. Is there documentation of tolerability and a positive clinical response to the medication?

☐ Yes ☐ No

Q6. Is the patient less than 4 years of age?

☐ Yes ☐ No

Q7. Is the requested medication being prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

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☐ Yes ☐ No

Q8. Is the requested drug being prescribed by or in consultation with ONE of the following: A) pediatric neurologist, B) child and adolescent psychiatrist, C) child development pediatrician?

☐ Yes ☐ No

Q9. Does the patient have chart documented evidence of a comprehensive evaluation by or in consultation with ONE of the following: A) pediatric neurologist, B) child and adolescent psychiatrist, C) child development pediatrician?

☐ Yes ☐ No

Q10. Is this a request for an analeptic Stimulant and Related agent?

☐ Yes ☐ No

Q11. Is the patient receiving concomitant treatment with sedative hypnotics?

☐ Yes ☐ No

Q12. Is the requested medication being prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q13. Does the patient have a diagnosis of narcolepsy or shift work sleep disorder confirmed according to the most recent consensus treatment guidelines (e.g., American Academy of Sleep Medicine International Classification of Sleep Disorders)?

☐ Yes ☐ No

Q14. Does the patient have a diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS)?

☐ Yes ☐ No

Q15. Has the patient's diagnosis of OSAHS been confirmed according to the most recent consensus treatment guidelines (e.g., American Academy of Sleep Medicine International Classification of Sleep Disorders)?

☐ Yes ☐ No

Q16. Does the patient have documentation of therapeutic failure of continuous positive airway pressure (CPAP) to resolve excessive daytime sleepiness (documented by either Epworth Sleepiness Scale greater than 10 or MSLT less than 8 minutes) with documented compliance to CPAP treatment?

☐ Yes ☐ No

Q17. Does the patient have a medical reason continuous positive airway pressure (CPAP) cannot be used?

☐ Yes ☐ No

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Q18. Does the patient have documentation of a therapeutic failure of an oral appliance for obstructive sleep apnea/hypopnea syndrome (OSAHS)?

☐ Yes ☐ No

Q19. Does the patient have the diagnosis of multiple sclerosis-related fatigue?

☐ Yes ☐ No

Q20. Is the patient receiving treatment for multiple sclerosis?

☐ Yes ☐ No

Q21. Do the patient's medical records document the rationale for not receiving treatment for multiple sclerosis?

☐ Yes ☐ No

Q22. Is this a request for a preferred analeptic Stimulants and Related Agent?

☐ Yes ☐ No

Q23. Does the patient have a documented therapeutic failure, contraindication to, or intolerance of the preferred analeptic Stimulants and Related agents approved or medically accepted for the patient's diagnosis ?

☐ Yes ☐ No

Q24. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q25. Is the requested medication being prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q26. Does the patient have a diagnosis of attention-deficit hyperactivity disorder (ADHD) documented by a history consistent with the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria?

☐ Yes ☐ No

Q27. Does the patient have a diagnosis of moderate to severe binge eating disorder?

☐ Yes ☐ No

Q28. Is the patient's diagnosis documented by a history consistent with the current Diagnostic and Statistical Manual (DSM) criteria?

☐ Yes ☐ No

Q29. Does the patient have a concurrent diagnosis of attention-deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD)?

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☐ Yes ☐ No

Q30. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of selective serotonin reuptake inhibitors (SSRIs) OR topiramate?

☐ Yes ☐ No

Q31. Does the patient have a documentation of a referral for cognitive behavioral therapy or other psychotherapy?

☐ Yes ☐ No

Q32. Does the patient have a diagnosis of narcolepsy confirmed according to the most recent consensus treatment guidelines (e.g., American Academy of Sleep Medicine International Classification of Sleep Disorders)?

☐ Yes ☐ No

Q33. Is the request for a stimulant?

☐ Yes ☐ No

Q34. Has the patient been assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by the prescriber?

☐ Yes ☐ No

Q35. Is there documentation that the patient has been educated on the potential adverse effects of stimulants, including the risk for misuse, abuse, and addiction?

☐ Yes ☐ No

Q36. Is there documentation that the prescriber or prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the patient's controlled substance prescription history?

☐ Yes ☐ No

Q37. Does the patient have a history of comorbid substance dependency, abuse, or diversion?

☐ Yes ☐ No

Q38. Does the patient have results of a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances?

☐ Yes ☐ No

Q39. Is this a request for guanfacine extended-release (Intuniv), Kapvay (clonidine ER) or an analeptic Stimulants and Related Agent?

☐ Yes ☐ No

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Q40. Is this a request for a Stimulant and Related agent drug when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q41. Is the patient being transitioned to another Stimulants and Related agent with the same duration of action (i.e., short-acting or long-acting) with the intent of discontinuing one of the medications?

☐ Yes ☐ No

Q42. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q43. Is this a request for a preferred Stimulant or Related agent drug?

☐ Yes ☐ No

Q44. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred Stimulants and Related agents approved or medically accepted for the patient's diagnosis?

☐ Yes ☐ No

Q45. Does the patient have a current history (within the past 90 days) of being prescribed the same requested non-preferred stimulant and related agent drug?

☐ Yes ☐ No

Q46. Additional Information:

Prescriber Signature

Date

Updated for 2021