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 this a request for Spravato (esketamine)?

☐ Yes ☐ No

Q2. Is Spravato (esketamine) prescribed by or in consultation with a psychiatrist?

☐ Yes ☐ No

Q3. Is Spravato (esketamine) prescribed in conjunction with a therapeutic dose of an oral antidepressant?

☐ Yes ☐ No

Q4. Does the member have severe hepatic impairment (Child-Pugh class C)?

☐ Yes ☐ No

Q5. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q6. Does the member still meet the following criteria: Spravato is prescribed by or in consultation with a psychiatrist; Spravato is prescribed in conjunction with a therapeutic dose of an oral antidepressant; and patient does not have severe hepatic impairment?

☐ Yes ☐ No

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

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q8. Does the patient have a current history (within the past 90 days) of being prescribed the requested non-preferred antidepressant drug?

☐ Yes ☐ No

Q9. 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

Q10. Is the requested drug age-appropriate for the patient according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q11. Is the patient prescribed a dose and frequency that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q12. Does the patient have a history of contraindication to the prescribed medication?

☐ Yes ☐ No

Q13. Does the patient meet at least 2 of the following? If YES, approve for 12 months. If NO, refer to Medical Director. A). Documented history of therapeutic failure, intolerance of, or contraindication to the preferred Antidepressants, Other approved or medically accepted for the patient's diagnosis at maximally tolerated doses for a duration of greater than or equal to six weeks; B). Documented history of therapeutic failure, intolerance of, or contraindication of the Antidepressants, SSRIs approved or medically accepted for the patient's diagnosis at maximally tolerated doses for a duration of greater than or equal to six weeks; C). Documented history of therapeutic failure, intolerance of, or contraindication of augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant approved or medically accepted for the patient's diagnosis at maximally tolerated doses for a duration of greater than or equal to six weeks.

☐ Yes ☐ No

Q14. Additional Information:

Prescriber Signature

Date

Updated for 2021

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