



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, Strength, Refills, Specialty Pharmacy.

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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Patient Name: Prescriber Name:

Form with 17 questions (Q8-Q17) regarding drug coverage, including questions about prescriber type, patient history, and medical necessity. Each question has Yes/No checkboxes.

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Patient Name:	Prescriber Name:
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<p>Q18. Does the patient have documentation of a therapeutic failure of an oral appliance for obstructive sleep apnea/hypopnea syndrome (OSAHS)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q19. Does the patient have the diagnosis of multiple sclerosis-related fatigue?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q20. Is the patient receiving treatment for multiple sclerosis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q21. Do the patient's medical records document the rationale for not receiving treatment for multiple sclerosis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q22. Is this a request for a preferred analeptic Stimulants and Related Agent?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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 ?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q24. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q27. Does the patient have a diagnosis of moderate to severe binge eating disorder?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q28. Is the patient's diagnosis documented by a history consistent with the current Diagnostic and Statistical Manual (DSM) criteria?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q29. Does the patient have a concurrent diagnosis of attention-deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD)?</p>

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Patient Name: Prescriber Name:

Form with 13 rows of questions (Q30-Q39) regarding patient history, diagnosis, and request details, each with Yes/No checkboxes.



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Patient Name: Prescriber Name:

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)?
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?
Q42. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?
Q43. Is this a request for a preferred Stimulant or Related agent drug?
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?
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?
Q46. Additional Information:

Prescriber Signature

Date

Updated for 2022