Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Analgesics - Non-Opioid Barbituate Combinations

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 being prescribed for an indication that is included in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q2. Is the requested drug age-appropriate for the patient according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Is the patient 65 years of age or older?

☐ Yes ☐ No

Q4. Has the patient received a risk assessment by the prescriber AND is there documentation of prescriber counseling regarding the potential increased risks of the requested drug?

☐ Yes ☐ No

Q5. Does the prescriber indicate that the benefits of the requested drug outweigh the risks for the patient?

☐ Yes ☐ No

Q6. Is there documentation of prescriber counseling regarding the potential increased risks of the requested drug?

☐ Yes ☐ No

Q7. Is the patient taking primidone or other medication(s) containing a barbiturate?

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☐ Yes ☐ No

Q8. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q9. Will the patient be taking the requested drug more than three (3) days per month?

☐ Yes ☐ No

Q10. Does the patient have a diagnosis of headache based on the most current International Headache Society Classification of Headache Disorders?

☐ Yes ☐ No

Q11. Does the patient have a documented history of trial and failure of, intolerance of, or contraindication to standard abortive medication based on headache classification as recommended by the most recent American Academy of Neurology, American Academy of Family Physicians, World Health Organization, or the European Academy of Neurology treatment guidelines?

☐ Yes ☐ No

Q12. Is the patient being treated for chronic daily headache, defined as the presence of headache on 15 days or more per month for at least three (3) months?

☐ Yes ☐ No

Q13. Does the patient have documentation of results of a physical examination and complete neurological examination to rule out secondary causes of headache?

☐ Yes ☐ No

Q14. Does the patient have documentation of an evaluation for the overuse of abortive medications, including but not limited to acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), triptans, butalbital, caffeine, and opioids?

☐ Yes ☐ No

Q15. Does the patient have documentation of prescriber counseling regarding behavioral modifications such as cessation of caffeine and tobacco use, improved sleep hygiene, diet changes, and regular mealtimes?

☐ Yes ☐ No

Q16. Is the patient taking preventive drug therapy based on headache classification as recommended by the most recent American Academy of Neurology, American Academy of Family Physicians, World Health Organization, or European Academy of Neurology treatment guidelines?

☐ Yes ☐ No

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Q17. Does the patient have a contraindication to or intolerance of standard preventive drug therapies?

☐ Yes ☐ No

Q18. Does the patient have documentation of prescriber counseling regarding the potential adverse effects of the requested drug, including the risk of medication overuse headache, misuse, abuse, and addiction?

☐ Yes ☐ No

Q19. Does the patient have a history of substance use disorder?

☐ Yes ☐ No

Q20. Does the patient have results of a recent urine drug screen (UDS) 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

Q21. Is the patient being treated by a prescribing provider who confirms that he or she, or the prescribing provider's delegate, conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the patient's controlled substance prescription history before prescribing the requested drug?

☐ Yes ☐ No

Q22. Is this a request for a preferred drug?

☐ Yes ☐ No

Q23. Does the patient have a documented history of therapeutic failure, a contraindication to, or intolerance of the preferred agents?

☐ Yes ☐ No

Q24. Additional Information:

Prescriber Signature

Date

Updated for 2022