



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Alzheimer's 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 a renewal of authorization?

Yes checkbox

No checkbox

Q2. Does the patient have a documented rationale for continuing the requested medication?

Yes checkbox

No checkbox

Q3. Does the patient's diagnosis meet ANY of the following: A) indicated in the package insert, B) listed in a nationally recognized compendia for the determination of medically-accepted indications for off-label use, C) supported by peer reviewed medical literature provided by the prescriber?

Yes checkbox

No checkbox

Q4. Is this a request for a preferred Alzheimer's Agent (e.g., donepezil 5 mg and 10 mg tablet, galantamine tablet, memantine tablet, rivastigmine capsule)?

Yes checkbox

No checkbox

Q5. Does the patient have a history of therapeutic failure, a contraindication to, or intolerance of the preferred Alzheimer's Agents (e.g., donepezil 5 mg and 10 mg tablet, galantamine tablet, memantine tablet, rivastigmine capsule)?

Yes checkbox

No checkbox

Q6. Is this a request for an acetylcholinesterase inhibitor when the patient has a recent paid claim for an acetylcholinesterase inhibitor (i.e., potential therapeutic duplication)?

Yes checkbox

No checkbox



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Patient Name: Prescriber Name:

Q7. Is the patient being titrated to, or tapered from, another acetylcholinesterase inhibitor?

Yes checkbox

No checkbox

Q8. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

Yes checkbox

No checkbox

Q9. Additional Information:

Prescriber Signature

Date

Updated for 2022