



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

VMAT2 Inhibitors

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, etc.

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 continuation of therapy with the requested agent?

Yes No

Q2. Is patient being prescribed a vesicular monoamine transporter-2 (VMAT2) inhibitor by, or in consultation with, a neurologist or a psychiatrist?

Yes No

Q3. Is the patient of an appropriate age according to Food and Drug Administration (FDA)-approved package labeling, compendia, or peer-reviewed medical literature?

Yes No

Q4. Is there documentation that the patient has a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling, OR is listed in nationally recognized compendia for the determination of medically-accepted indications for off-label uses for the prescribed agent?

Yes No

Q5. Does the patient have a contraindication to the prescribed agent?

Yes No

Q6. Does the patient have a history of a prior suicide attempt, bipolar disorder, or major depressive disorder?

Yes No

Q7. Has the patient had a mental health evaluation performed?



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Patient Name:	Prescriber Name:
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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Has the patient been evaluated within the previous 6 months and treated by a psychiatrist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the patient being treated for a diagnosis of tardive dyskinesia?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Was the patient assessed for and determined to have no other causes of involuntary movement?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Was the patient evaluated for appropriateness of dose reduction of dopamine receptor blocking agents?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Is there documentation of tardive dyskinesia severity using a validated scale or assessment of impact on daily function?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Is this a request for a non-preferred vesicular monoamine transporter-2 (VMAT2) inhibitor?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Is there documentation of therapeutic failure or intolerance to the preferred vesicular monoamine transporter-2 (VMAT2) inhibitors?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Does the patient have a diagnosis of chorea?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Has the patient experienced a clinical benefit from treatment with the prescribed agent based on the prescriber's clinical judgment?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Does the patient have a diagnosis of tardive dyskinesia?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Has the patient experienced an improvement in tardive dyskinesia severity documented by a validated scale or improvement in daily function?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Does the patient have a contraindication to the prescribed agent?	

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Yes

No

Q20. Has the patient been re-evaluated and treated for new onset or worsening symptoms of depression and determined to continue to be a candidate for treatment with the prescribed agent?

Yes

No

Q21. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated for 2022*