



**HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

**Antiparasitics - Topical**

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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

<p>Q1. Does the patient have a documented history of therapeutic failure, a contraindication to, or intolerance of the preferred products (e.g., piperonyl butoxide/pyrethrum shampoo, permethrin cream rinse 1 percent, Natroba topical suspension, permethrin 5 percent cream, Sklice lotion)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q2. Is this a request for lindane shampoo?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q3. Does the patient weigh 50 pounds or greater?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q4. Does the patient take any medications that may reduce the seizure threshold (such as but not limited to: meperidine, cyclosporine, theophylline)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q5. Additional Information:</p>

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

\_\_\_\_\_  
Date

*Updated for 2022*