



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Neuropathic Pain 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.

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 neuropathic pain agent that is subject to the Drug Enforcement Agency (DEA) Controlled Substances Act (CSA) (i.e., controlled substance)?

Yes No

Q2. Is there documentation that the prescriber or the prescriber's delegate has conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the patient's controlled substance prescription history?

Yes No

Q3. Is this a request for a renewal of authorization?

Yes No

Q4. Does the patient have documentation of tolerability and a positive clinical response to the medication?

Yes No

Q5. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?

Yes No

Q6. Is the patient being prescribed a dose that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q7. Is this a request for a gabapentinoid (e.g., gabapentin, pregabalin) when there is a recent paid claim for another

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Patient Name:	Prescriber Name:
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gabapentinoid (i.e., potential therapeutic duplication)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Is the patient being titrated to or tapered from another gabapentinoid? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q9. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q10. Is this a request for Gralise (gabapentin extended-release)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q11. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of tricyclic antidepressants AND regular-release gabapentin titrated to maximal effective dose of 1800 mg per day? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q12. Is this a request for Horizant (gabapentin enacarbil extended-release)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q13. Does the patient have a diagnosis of postherpetic neuralgia? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q14. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of tricyclic antidepressants AND regular-release gabapentin titrated to maximal effective dose of 1800 mg per day? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q15. Does the patient have a diagnosis of moderate-to-severe primary restless leg syndrome (RLS)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q16. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of regular-release gabapentin, titrated to maximal tolerated effective dose of 1800 mg per day? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q17. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of pramipexole OR ropinirole? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q18. Is this a request for a preferred neuropathic pain agent? <input type="checkbox"/> Yes <input type="checkbox"/> No

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Patient Name: Prescriber Name:

Q19. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred neuropathic pain agents that are approved or medically accepted for the patient's diagnosis?

Yes

No

Q20. Additional Information:

Prescriber Signature

Date

Updated for 2022