Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Cymbalta

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 medication being used as an antidepressant or a neuropathic pain agent?

☐ Antidepressant ☐ Neuropathic pain agent

Q2. Does the patient have a current history (within the past 90 days) of being prescribed the requested non-preferred antidepressant drug?

☐ Yes ☐ No

Q3. Is the requested drug being prescribed for the treatment of a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q4. Is the requested drug age-appropriate for the patient according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Is the patient prescribed a dose and frequency that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q6. Does the patient have a history of contraindication to the prescribed medication?

☐ Yes ☐ No

Q7. Does the patient meet at least two of the following?

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Patient Name:	Prescriber Name:

a. History of therapeutic failure, contraindication, or intolerance of the preferred Antidepressants, Other approved or medically accepted for the patient's diagnosis at maximally tolerated doses for a duration of greater than or equal to 6 weeks,
b. History of therapeutic failure, contraindication, or intolerance of the Antidepressants, SSRIs approved or medically accepted for the patient's diagnosis at maximally tolerated doses for a duration of greater than or equal to 6 weeks,
c. History of therapeutic failure, contraindication, or intolerance of augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant approved or medically accepted for the patient's diagnosis at maximally tolerated doses for a duration of greater than or equal to 6 weeks.

☐ Yes ☐ No

Q8. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q9. Does the patient have documentation of tolerability and a positive clinical response to the medication?

☐ Yes ☐ No

Q10. 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

Q11. 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

Q12. For a non-preferred neuropathic pain agent, 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

Q13. Requested Duration:

☐ 12 Months

Q14. Additional Information:

Prescriber Signature _____ Date _____

Updated for 2022