

## HEALTH PARTNERS PLANS 2023 PRIOR AUTHORIZATION REQUEST FORM

## 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.

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Patient Name:	Prescriber Name:	
HPP 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: ð Medicaid ð 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 portinent medical history including lah	e and information for this mo	mhor that may support approval
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. 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)?		
☐ Yes	□ No	
Q2. Is this a request for lindane shampoo?		
☐ Yes	□No	
Q3. Does the patient weigh 50 kilograms or greater?		
☐ Yes	□No	
Q4. Does the patient take any medications that may reduce the seizure threshold (such as but not		
limited to: meperidine, cyclosporine, theophylline	e)?	
☐ Yes	□ No	
Q5. Additional Information:		
Prescriber Signature		 Date
riescriber signature		Date

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Patient Name:	Prescriber Name:

Updated for 2023