Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Local Anesthetics - 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: ☐ 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 this a request for lidocaine viscous oral solution or lidocaine oral jelly?

☐ Yes ☐ No

Q2. Is the patient 3 years of age or older?
[Note: Prior Authorization for lidocaine viscous oral solution or lidocaine oral jelly is only required for patients less than 3 years of age.]

☐ Yes ☐ No

Q3. Is the requested drug being prescribed for the treatment of teething pain?

☐ Yes ☐ No

Q4. Does the patient have documented therapeutic failure, contraindication to, or intolerance of alternative recommended treatments for the patient's indication?

☐ Yes ☐ No

Q5. Is the patient prescribed a dose that is consistent with United States Food and Drug Administration (US FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q6. Does the patient have a documented history of therapeutic failure, intolerance of, or contraindication to the preferred topical local anesthetic drugs?

☐ Yes ☐ No

Q7. Additional Information:

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Patient Name:	Prescriber Name:

_____ _____

Prescriber Signature Date

Updated for 2023