Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Anticonvulsants

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 a gabapentinoid (e.g., gabapentin, pregabalin) when there is a recent paid claim for another gabapentinoid (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q2. Is the patient being titrated to, or tapered from, another gabapentinoid?

☐ Yes ☐ No

Q3. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q4. Is this a request for clonazepam?

☐ Yes ☐ No

Q5. Is the patient less than 21 years of age?

☐ Yes ☐ No

Q6. Does the patient have any of the following diagnoses: A) seizure disorder, B) chemotherapy-induced nausea and vomiting, C) cerebral palsy, D) spastic disorder, E) dystonia?

☐ Yes ☐ No

Q7. Is the patient receiving palliative care?

☐ Yes ☐ No

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Anticonvulsants

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:

Q8. Does the patient have a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder?

☐ Yes ☐ No

Q9. Are the prescriptions for the buprenorphine agent and the benzodiazepine written by the same prescriber?

☐ Yes ☐ No

Q10. Are the prescribers of the buprenorphine agent and the benzodiazepine aware of the other prescriptions?

☐ Yes ☐ No

Q11. Does the patient have an acute need for therapy with a benzodiazepine?

☐ Yes ☐ No

Q12. Is this a request for clonazepam when the patient has a recent claim for another benzodiazepine (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q13. Is the patient being titrated to, or tapered from, another benzodiazepine?

☐ Yes ☐ No

Q14. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q15. Does the patient have a record of 2 or more paid claims for any benzodiazepine in the past 30 days?

☐ Yes ☐ No

Q16. Are the multiple benzodiazepine prescriptions consistent with medically accepted prescribing practices and standards of care, including support from peer-reviewed literature or national treatment guidelines that corroborate the use of the quantity of medication being prescribed?

☐ Yes ☐ No

Q17. Are all of the prescriptions written by the same prescriber?

☐ Yes ☐ No

Q18. Are all of the prescribers aware of the other prescription(s)?

☐ Yes ☐ No

Q19. Is there documentation that the prescriber, or the prescriber's delegate, conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the patient's controlled substance prescription history?

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Anticonvulsants

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:

☐ Yes	☐ No
Q20. Is this a request for a preferred anticonvulsant? ☐ Yes	☐ No
Q21. Does the patient have a current history (within the past 90 days) of being prescribed the requested non-preferred anticonvulsant? ☐ Yes	☐ No
Q22. Does the patient have a documented history of therapeutic failure, intolerance of, or contraindication to the preferred anticonvulsants approved or medically accepted for the patient's diagnosis? [Note: Therapeutic failure of preferred anticonvulsants MUST include the generic equivalent when the generic equivalent is designated as preferred.] ☐ Yes	☐ No
Q23. 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
Q24. Is the patient 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
Q25. Is the requested drug age-appropriate for the patient according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature? ☐ Yes	☐ No
Q26. Additional Information:	

_____ _____

Prescriber Signature Date

Updated for 2023