

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.

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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:		Remis.		
	Diagnosia			
Diagnosis Code: Diagnosis: HPP's maximum approval time is 12 months but may be less depending on the drug.				
HPP's maximum approv	ai time is 12 mo	ontns but may be less o	depending on the drug.	
Please attach any pertinent medical history	y including lab	s and information for	this member that may support approval.	
	_	llowing questions and		
		<u> </u>		
Q1. Is this a request for lidocaine viscous or	rai solution or	ildocaine oral jelly?		
Yes	es			
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 a approved package labeling, nationally recognition				
Yes		☐ No		
Q6. Does the patient have a documented hi preferred topical local anesthetic drugs?	istory of thera	peutic failure, intolera	ance of, or contraindication to the	
☐Yes		☐ No		
Q7. Additional Information:				

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Patient Name:	Prescriber Name:
Prescriber Signature	 Date

Updated for 2023