Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

VMAT2 Inhibitors

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 continuation of therapy with the requested agent?

☐ Yes ☐ No

Q2. Is patient being prescribed a vesicular monoamine transporter-2 (VMAT2) inhibitor by, or in consultation with, a neurologist or a psychiatrist?

☐ Yes ☐ No

Q3. Is the patient of an appropriate age according to Food and Drug Administration (FDA)-approved package labeling, compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is there documentation that the patient has a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling, OR is listed in nationally recognized compendia for the determination of medically-accepted indications for off-label uses for the prescribed agent?

☐ Yes ☐ No

Q5. Does the patient have a contraindication to the prescribed agent?

☐ Yes ☐ No

Q6. Does the patient have a history of a prior suicide attempt, bipolar disorder, or major depressive disorder?

☐ Yes ☐ No

Q7. Has the patient had a mental health evaluation performed?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Has the patient been evaluated within the previous 6 months and treated by a psychiatrist?	
☐ Yes	☐ No
Q9. Is the patient being treated for a diagnosis of tardive dyskinesia?	
☐ Yes	☐ No
Q10. Was the patient assessed for and determined to have no other causes of involuntary movement?	
☐ Yes	☐ No
Q11. Was the patient evaluated for appropriateness of dose reduction of dopamine receptor blocking agents?	
☐ Yes	☐ No
Q12. Is there documentation of tardive dyskinesia severity using a validated scale or assessment of impact on daily function?	
☐ Yes	☐ No
Q13. Is this a request for a non-preferred vesicular monoamine transporter-2 (VMAT2) inhibitor?	
☐ Yes	☐ No
Q14. Is there documentation of therapeutic failure or intolerance to the preferred vesicular monoamine transporter-2 (VMAT2) inhibitors?	
☐ Yes	☐ No
Q15. Does the patient have a diagnosis of chorea?	
☐ Yes	☐ No
Q16. Has the patient experienced a clinical benefit from treatment with the prescribed agent based on the prescriber's clinical judgment?	
☐ Yes	☐ No
Q17. Does the patient have a diagnosis of tardive dyskinesia?	
☐ Yes	☐ No
Q18. Has the patient experienced an improvement in tardive dyskinesia severity documented by a validated scale or improvement in daily function?	
☐ Yes	☐ No
Q19. Does the patient have a contraindication to the prescribed agent?	

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q20. Has the patient been re-evaluated and treated for new onset or worsening symptoms of depression and determined to continue to be a candidate for treatment with the prescribed agent? ☐ Yes	☐ No
Q21. Additional Information:	

_____ _____

Prescriber Signature Date

Updated for 2023