HIGHMARK HEALTH OPTIONS

Updated: 04/2024
DMMA Approved: 04/2024

Request for Prior Authorization for Duplicate Therapy
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Duplicate Therapy require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Duplicate Therapy Prior Authorization Criteria:

All requests for medications within the classes listed below will require a Prior Authorization when the member is prescribed more than one medication in the same therapeutic class within a 30 day period (therapeutic duplication). Requests for therapeutic duplication will be reviewed for medical necessity and appropriateness.

The Pharmacy Department will follow the procedures outlined in CP-206-MD-DE after receiving a request for a Prior Authorization for requests for use of more than one medication in the following therapeutic classes:

- Long-Acting Narcotic Analgesics
- Non-benzodiazepine hypnotics (i.e. zolpidem, eszopiclone, etc.)
- Oral Anticoagulants
- Skeletal Muscle Relaxants
- Benzodiazepines
- Hereditary Angioedema Acute Attack Agents
- Hereditary Angioedema Prophylaxis Agents
- Gabapentinoids
- Glucagon-Like Peptide-1 Receptor Antagonists and Dipeptidyl Peptidase IV Inhibitors

In evaluating a request for Prior Authorization of a prescription that duplicates therapy, the determination of whether the requested prescription is medically necessary will take into account the following:

1. The member's diagnosis;
2. Whether the member is being titrated to, or tapered from a drug in the same class.
3. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested.

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THERAPEUTIC DUPLICATION PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services.
FAX: (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

☐ What is the member's diagnosis: _____
☐ Is the member being tapered off a medication? ☐ Yes ☐ No Name of medication being stopped: _____ Name of medication being started: _____

Please provide any other necessary information for why the member requires treatment with more than one medication from the same therapeutic class (i.e. chart notes, lab results, etc.):

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)