Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antifibrotic Respiratory Agents

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 request for renewal of therapy (i.e., The requested drug has been previously approved on prior authorization)?

☐ Yes ☐ No

Q2. Is the requested drug being prescribed for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q4. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Is the requested drug prescribed by or in consultation with an appropriate specialist (e.g., pulmonologist, rheumatologist, etc.)?

☐ Yes ☐ No

Q6. Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug or counseling of the beneficiary of the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q7. Does the patient have a history of a contraindication to the prescribed medication?

☐ Yes ☐ No

Q8. Does the patient currently smoke?

☐ Yes ☐ No

Q9. Is there documentation of being advised by the prescriber to stop smoking?

☐ Yes ☐ No

Q10. Is the requested drug a non-preferred idiopathic pulmonary fibrosis (IPF) agent?

☐ Yes ☐ No

Q11. Does the patient have history of therapeutic failure, contraindication or intolerance to the preferred idiopathic pulmonary fibrosis (IPF) agents approved or medically accepted for the patient's indication?

☐ Yes ☐ No

Q12. Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred idiopathic pulmonary fibrosis (IPF) agent?

☐ Yes ☐ No

Q13. Is the patient benefitting from the requested drug, based on the prescriber's assessment?

☐ Yes ☐ No

Q14. Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug or counseling of the beneficiary of the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

Q15. Is the requested drug prescribed by or in consultation with an appropriate specialist (e.g., pulmonologist, rheumatologist, etc.)?

☐ Yes ☐ No

Q16. Does the patient have a history of a contraindication to the prescribed drug?

☐ Yes ☐ No

Q17. Additional Information:

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Patient Name:	Prescriber Name:

Prescriber Signature Date

Updated for 2023