Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Intranasal Rhinitis 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 a request for triamcinolone nasal spray?

☐ Yes ☐ No

Q2. Is the patient 4 years of age or older?
[Note: Prior Authorization is not required for triamcinolone nasal spray for patients less than 4 years of age.]

☐ Yes ☐ No

Q3. Is this a request for an intranasal rhinitis drug (i.e., intranasal antihistamine or intranasal steroid) when there is a record of a recent paid claim for another intranasal rhinitis drug with the same mechanism of action (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q4. Is the patient being titrated to or tapered from another intranasal rhinitis drug containing a drug with the same mechanism of action?

☐ Yes ☐ No

Q5. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q6. Is this a request for a preferred intranasal rhinitis drug?

☐ Yes ☐ No

Q7. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of a preferred intranasal

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rhinitis drug with the same mechanism of action?

☐ Yes ☐ No

Q8. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023