Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Pulmozyme

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 the requested drug being prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of cystic fibrosis? (Please attach documentation of diagnosis)?

☐ Yes ☐ No

Q3. Is Pulmozyme being prescribed in conjunction with standard therapies (such as CFTR [cystic fibrosis transmembrane conductance regulator] modulators, oral, inhaled and/or parenteral antibiotics, bronchodilators, pancreatic enzyme supplements, vitamins, oral or inhaled corticosteroids, inhaled hypertonic saline, analgesics, and chest physiotherapy) for cystic fibrosis?

☐ Yes ☐ No

Q4. Will the requested drug be administered using a recommended jet nebulizer/compressor system or eRapid Nebulizer System?

☐ Yes ☐ No

Q5. Is the requested drug being prescribed at a dose of 2.5 mg once daily?

☐ Yes ☐ No

Q6. Is the requested drug being prescribed at a dose of 2.5 mg twice daily?

☐ Yes ☐ No

Q7. Has documentation of an adequate trial of once daily dosing consisting of at least a 2 week trial been submitted? [Please attach documentation of previous trial.]

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Additional Information:	

_____ _____

Prescriber Signature Date

Updated for 2023