Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Thalidomide and Derivatives

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 medication prescribed by or in consultation with an appropriate specialist (i.e., hematologist/oncologist)?

☐ Yes ☐ No

Q2. Is the prescribed dose and duration of therapy consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Is this a request for continuation of therapy?

☐ Yes ☐ No

Q4. Is the requested medication 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

Q5. Is the request for a non-preferred agent?

☐ Yes ☐ No

Q6. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to the preferred Thalidomide and Derivatives approved or medically accepted for the beneficiary's diagnosis?
[Note: documentation must be attached.]

☐ Yes ☐ No

Q7. Is documentation of the therapeutic failure, contraindication, or intolerance to the preferred Thalidomide and

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Derivatives attached to this request?

☐ Yes ☐ No

Q8. Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred Thalidomide and Derivative?

☐ Yes ☐ No

Q9. Has the patient been tolerant to the requested medication and had a positive clinical response to the medication? [Note: documentation must be attached.]

☐ Yes ☐ No

Q10. Is documentation of tolerability and positive clinical response attached to this request?

☐ Yes ☐ No

Q11. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023