HEALTH PARTNERS PLANS

PRIOR AUTHORIZATION REQUEST FORM

Antipsoriatics - Topical

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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member 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 prescribed for the treatment of a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q2. Is the requested drug age-appropriate for the patient according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Does the patient have a contraindication to the prescribed medication?

☐ Yes ☐ No

Q4. For a topical AhR agonist (Vtama),
a. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to a 4-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis; -AND-
b. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to an 8-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis

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Member Name:	Prescriber Name:

☐ Yes ☐ No

Q5. For a topical PDE4 inhibitor (Zoryve).
a. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to a 4-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis -AND-
b. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to an 8-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis

☐ Yes ☐ No

Q6. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred topical antipsoriatic agents?

☐ Yes ☐ No

Q7. Additional Information:

______________________________ ____________________

Prescriber Signature Date

v2025

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