HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Bronchodilators - Beta Agonist

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 this a request for a non-preferred oral beta agonist bronchodilator drug?

☐ Yes ☐ No

Q2. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred inhaled beta agonist bronchodilators approved or medically accepted for the patient's diagnosis or indication?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of asthma?

☐ Yes ☐ No

Q4. Does the patient have a concomitant prescription for an inhaled steroid?

☐ Yes ☐ No

Q5. Is this a request for a preferred inhaled long-acting beta agonist bronchodilator drug?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q6. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred long-acting beta agonist bronchodilator drugs?

☐ Yes ☐ No

Q7. Is this a request for an inhaled long-acting beta agonist bronchodilator drug when there is a record of a recent paid claim for another drug containing an inhaled long-acting beta agonist (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q8. Is this a request for a non-preferred inhaled short-acting beta agonist bronchodilator drug?

☐ Yes ☐ No

Q9. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred inhaled short-acting beta agonist bronchodilator drugs?

☐ Yes ☐ No

Q10. Is the patient being titrated to or tapered from a drug in the same class?

☐ Yes ☐ No

Q11. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q12. Additional Information:

Prescriber Signature

Date

v2025