HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

HIV-AIDS Antiretrovirals

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 in the same class of drugs as a drug that the patient is already receiving?

☐ Yes ☐ No

Q2. Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred HIV/AIDS Antiretroviral?
Note: Does not apply non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred.

☐ Yes ☐ No

Q3. Does the patient have a documented history of contraindication, intolerance, or lab test results showing resistance to the preferred HIV/AIDS Antiretrovirals with the same mechanism of action as the requested agent?

☐ Yes ☐ No

Q4. Is the requested drug prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling a medically accepted indication?

☐ Yes ☐ No

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Q5. Is the requested dose consistent with the U.S. Food and Drug Administration (FDA))-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q6. For an NNRTI, is the patient being transitioned to another NNRTI with the intent of discontinuing one of the medications?

☐ Yes ☐ No

Q7. For a protease inhibitor, is the patient being transitioned to another protease inhibitor with the intent of discontinuing one of the medications?

☐ Yes ☐ No

Q8. For an integrase strand transfer inhibitor, is the patient being transitioned to another integrase strand transfer inhibitor with the intent of discontinuing one of the medications?

☐ Yes ☐ No

Q9. For a single product regimen, is the patient being transitioned to another single product regimen with the intent of discontinuing one of the medications?

☐ Yes ☐ No

Q10. Does the patient have a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?

☐ Yes ☐ No

Q11. Additional Information:

_____ _____

Prescriber Signature Date

v2025

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