

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Macrolides

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:			
Date of Birth: Patient Primary Phone: NPI: PA PROMISe ID: Address: City, State ZIP: City, State ZIP: City, State ZIP: Specialty Pharmacy (if applicable): Drug Name: Quantity: Paramacy (if applicable): Diagnosis: Nefills: 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. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred macrolide drugs approved or medically accepted for the patient's diagnosis? Yes No Q2. Does the patient have culture and sensitivity test results documenting that only non-preferred macrolide drugs will be effective? No	Patient Name:	Prescriber Name:	
Patient Primary Phone: Address: Address: City, State ZIP: Line of Business: Medicaid CHIP Specialty Pharmacy (if applicable): Drug Name: Quantity: 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. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred macrolide drugs approved or medically accepted for the patient's diagnosis? Yes	HPP Member Number:	Fax:	Phone:
Address: 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. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred macrolide drugs approved or medically accepted for the patient's diagnosis? Yes No Q2. Does the patient have culture and sensitivity test results documenting that only non-preferred macrolide drugs will be effective? Yes No	Date of Birth:	Office Contact:	
City, State ZIP: Line of Business:	Patient Primary Phone:	NPI:	PA PROMISe ID:
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. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred macrolide drugs approved or medically accepted for the patient's diagnosis? No Q2. Does the patient have culture and sensitivity test results documenting that only non-preferred macrolide drugs will be effective? No	Address:	Address:	
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be effective? Solution Yes No	☐ Yes	□No	
Q3. Additional Information:	Yes	☐ No	
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Prescriber Signature Date	Prescriber Signature		 Date

Updated for 2023