

## HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

#### Enzyme Replacements - Gaucher Disease

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.

1 == 10 = 110 1 = 1 7 mg matter (patient, proc	orribor, arag, labo	, ion siam, mognoto, or no	addenied THEE BEETT the ferror proceed	
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:		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
Diagnosis Code:	Diagnosis:			
		onths but may be less dep	pending on the drug	
THIT O MAXIMAM Approx	<i>(4) (11110 10 12 111</i> 0	shine but may be leed dep	ortaing 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 initial therapy with the requested agent? [If no, skip to question 12.]				
☐Yes		☐ No		
Q2. Is the requested drug being used for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA) – approved package labeling or a medically accepted indication?				
☐Yes		☐ No		
Q3. Is the patient age-appropriate for the requested drug according to Food and Drug Administration (FDA) – approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?				
Yes		☐ No		
Q4. Is the prescribed dose consistent with Food and Drug Administration (FDA) – approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?				
☐ Yes		☐ No		
Q5. Does the patient have a history of cont	raindication to	the requested drug?		
Yes		☐ No		
Q6. Is the requested medication prescribed disease?	l by or in consu	ultation with a specialis	t in the treatment of Gaucher	
Yes		☐ No		
Q7. Is this request for a non-preferred ager	nt?			

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



## HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

#### Enzyme Replacements - Gaucher Disease

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:
☐ Yes	□ No
Q8. Has the patient tried and failed or had a contraindical medically accepted for the patient's indication?	tion or intolerance to the preferred agents approved or
☐ Yes	□ No
Q9. Does the patient have a diagnosis of Gaucher diseas	se?
☐ Yes	□ No
Q10. Does the patient have one of the following: A) Enzy glucocerebrosidase (glucosidase) activity, B) Deoxyribon Please attach documentation of the lab test.	me assay demonstrating a deficiency of beta- ucleic acid (DNA) testing confirming the diagnosis? Note:
☐ Yes	□ No
Q11. Does the patient have a diagnosis of one of the follound interstitial lung disease, E) Splenomegaly, F) Thrombocy	owing: A) Anemia, B) Bone disease, C) Hepatomegaly, D) topenia? Note: Please attach documentation.
☐ Yes	□ No
Q12. Has the plan previously approved the requested druplan)?	ug for this patient (previous authorization is on file under this
☐ Yes	□ No
Q13. Is the prescribed dose consistent with Food and Dru nationally recognized compendia, or peer-reviewed media	
☐ Yes	□ No
Q14. Is the requested medication prescribed by or in condisease?	sultation with a specialist in the treatment of Gaucher
☐ Yes	□ No
Q15. Has the disease severity improved since initiating tr documentation of disease improvement.	reatment with the requested drug? Note: Please provide
☐ Yes	☐ No
Q16. Additional Information:	
Prescriber Signature	Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



# HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

#### Enzyme Replacements - Gaucher Disease

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:
	1

Updated for 2023