

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Intra-Articular Hyaluronates

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.

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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:		rtomo.		
	Diagnosia			
Diagnosis Code: Diagnosis: HPP's maximum approval time is 12 months but may be less depending on the drug.				
пер з тахітит аррго	/ai time is 12 mo	onths but may be less de	bending on the drug.	
Please attach any pertinent medical history including labs and information for this member that may support approval.				
	-	llowing questions and s		
Q1. Is this request for renewal of therapy?				
Yes	□ No			
Q2. Is the requested drug being used for a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?				
☐Yes				
Q3. Has the patient had a documented history of therapeutic failure, contraindication or intolerance to all of the following: A) Non-pharmacologic treatments, B) Acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs) and C) Intra-articular glucocorticoid injection?				
Yes		□No		
Q4. Does the member have a contraindication to the requested drug?				
☐Yes		□ No		
Q5. Is this a request for a non-preferred pro	oduct?			
Yes		□ No		
Q6. Has the member had a documented history or therapeutic failure, contraindication or intolerance to the preferred intra-articular hyaluronate products?				
Yes	☐ Yes ☐ No			
Q7. Has the member demonstrated improvattach documentation of this improvement.	ement in pain	or joint function followi	ng the first treatment? Note: Please	

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Patient Name:	Prescriber Name:		
☐ Yes	□ No		
Q8. Has the member received an intra-articular hyaluronate injection in the same knee within the past 6 months?			
☐Yes	□ No		
Q9. Does the member have a contraindication to the requested drug?			
☐Yes	□ No		
Q10. Additional Information:			
Prescriber Signature	Date		

Updated for 2023