

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Intranasal Rhinitis Agents

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:		
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:		110111101		
I	Diagnosis			
Diagnosis Code: Diagnosis: HPP's maximum approval time is 12 months but may be less depending on the drug.			er ere the endurer	
пРР's maximum approv	ai time is 12 mo	onths but may be less depending	g on the drug.	
Please attach any pertinent medical histor	y including lab	s and information for this me	mber that may support approval.	
Please	answer the fol	lowing questions and sign.		
Q1. Is this a request for triamcinolone nasal		<u> </u>		
_ `				
Yes	□ No			
Q2. Is the patient 4 years of age or older?				
[Note: Prior Authorization is not required for triamcinolone nasal spray for patients less than 4 years of age.]				
☐Yes	□No			
Q3. Is this a request for an intranasal rhiniting record of a recent paid claim for another into the the rapeutic duplication)?				
☐Yes		□ No		
Q4. Is the patient being titrated to or tapered mechanism of action?	d from anothe	r intranasal rhinitis drug cont	aining a drug with the same	
Yes		□ No		
Q5. Has the prescriber provided supporting concomitant use of the medications being re		d literature or national treatm	ent guidelines to corroborate	
Yes		☐ No		
Q6. Is this a request for a preferred intranas	sal rhinitis drug	 g?		
Yes		☐ No		
Q7. Does the patient have a history of thera	peutic failure.	contraindication to, or intole	rance of a preferred intranasal	

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Patient Name:	Prescriber Name:
rhinitis drug with the same mechanism of action? ☐ Yes	☐ No
Q8. Additional Information:	
 Prescriber Signature	

Updated for 2023