Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Urea Cycle Disorder 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:		
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 this a request for continuation of therapy with the requested drug (i.e., this medication was previously approved by a HPP prior authorization)?

☐ Yes ☐ No

Q2. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q3. Is there chart documentation supporting the diagnosis (e.g., ammonia levels, genetic testing, enzyme assays, plasma amino acid/urine orotic acid analyses, progress notes)?

☐ Yes ☐ No

Q4. Is the requested drug prescribed a dose and duration of therapy that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. If the requested drug a non-preferred urea cycle disorder agent?

☐ Yes ☐ No

Q6. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to the preferred urea cycle disorder agent?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q7. Is there documentation from the prescribing provider that the beneficiary had a positive clinical response to therapy?

☐ Yes ☐ No

Q8. Is the requested drug prescribed by or in consultation with a physician who specializes in treating metabolic disorders?

☐ Yes ☐ No

Q9. Is the requested drug prescribed a dose and duration of therapy that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q10. Requested Duration:

☐ 12 Months

Q11. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023