

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Antihistamines - Minimally Sedating

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	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 Pharma	acy (if applicable):	
Drug Name:	Strength:		
Quantity:		Refills:	
Directions:			
Diagnosis Code: Diagnosis	s:		
HPP's maximum approval time is 12 months but may be less depending on the drug.			
The Chamban approval and to 12 months satemay so look appointing that a day.			
Please attach any pertinent medical history including labs and information for this member that may support approval.			
Please answer the	following questions ar	nd sign.	
Q1. Is this a request for minimally-sedating antihistami minimally-sedating antihistamine drug (i.e., potential the			
Yes	es		
Q2. Is the patient being titrated to or tapered from anot	ther minimally-sedatin	g antihistamine drug?	
Yes	□ No		
Q3. Has the prescriber provided supporting peer review concomitant use of the medications being requested?	wed literature or nation	nal treatment guidelines to corroborate	
☐ Yes ☐ No			
Q4. Is this a request for a preferred minimally-sedating	antihistamine drug?		
☐ Yes ☐ No			
Q5. Does the patient have a history of therapeutic failu sedating antihistamine drugs?	ıre, contraindication to	, or intolerance of the preferred minimally-	
Yes	☐ No		
Q6. Additional Information:			
Prescriber Signature		Date	

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Updated for 2023