

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Anticoagulants

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:		- rtomoi		
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 the patient being prescribed a dose and duration of therapy that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?				
Yes		☐ No		
Q2. Does the patient have a history of a contraindication to the requested drug?				
☐ Yes ☐ No				
Q3. Is this a request for an oral or injectable anticoagulant when there is a record of a recently paid claim for another anticoagulant with the same route of administration (i.e., potential therapeutic duplication)?				
Yes		□ No		
Q4. Is the patient being titrated to or tapered from another anticoagulant with the same route of administration as the requested drug?				
☐ Yes		□ No		
Q5. Has the prescriber provided supporting concomitant use of the medications being r		d literature or national t	reatment guidelines to corroborate	
☐Yes		□ No		
Q6. Is this a request for a preferred anticoa	igulant drug?			
☐Yes		□ No		
Q7. Does the patient have a documented h preferred anticoagulant drugs approved or				

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Patient Name:	Prescriber Name:
☐ Yes	□ No
Q8. Additional Information:	
Prescriber Signature	Date

Updated for 2023