

## HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

## Acne Agents - Oral

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:		T T T T T T T T T T T T T T T T T T T		
Diagnosis Code:	Diagnosis:			
HPP's maximum approval time is 12 months but may be less depending on the drug.				
THE STHAMMAN approval line 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. Does the patient have a diagnosis that is indicated in the United States (US) Food and Drug Administration (FDA) approved package labeling OR a medically-accepted indication?				
☐ Yes ☐ No				
Q2. Is the patient of an appropriate age for the requested drug according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?				
Yes		□ No		
Q3. Is the patient 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		
Q4. Is the requested oral acne agent presc	ribed by or in o	consultation with a dern	natologist?	
Yes		□ No		
Q5. Is the requested drug being prescribed	for acne?			
☐ Yes ☐ No				
Q6. Does the patient have a history of there an oral antibiotic recommended for the trea acne, C) a topical retinoid?				
Yes		☐ No		
Q7. Is this a request for a preferred oral acr	ne agent (e.g.,	Amnesteem, Claravis,	, Myorisan, Zenatane)?	

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

Updated for 2023