Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Erythropoiesis Stimulating Agents (ESAs)

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 the prescribed ESA being used for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q2. Is the prescribed ESA by or in consultation with an appropriate specialist (i.e., gastroenterologist, hematologist/oncologist, infectious disease specialst, nephrologist, surgeon, etc)?

☐ Yes ☐ No

Q3. Does the patient have a contraindication to the prescribed ESA?

☐ Yes ☐ No

Q4. Is the prescribed dose and duration of therapy consistent with FDA- approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Has the patient been evaluated and treated for other causes of anemia (e.g. iron deficiency, hemolysis, vitamin B12 deficiency, folate deficiency, etc)?

☐ Yes ☐ No

Q6. Does the patient have a serum ferritin ≥ 100 mcg/L and serum transferrin saturation ≥ 20% OR receiving supplemental iron therpay?

☐ Yes ☐ No

Q7. Does the patient have the diagnosis of anemia associated with chronic kidney disease?

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☐ Yes	☐ No
Q8. Is this a request for continuation of therapy with the requested drug?	
☐ Yes	☐ No
Q9. Does the patient have a pretreatment hemoglobin ≤ 10 g/dL?	
☐ Yes	☐ No
Q10. Has the patient experienced a documented increase in hemoglobin or is prescribed an increased dose of the requested ESA consistent with FDA approved package labeling or peer reviewed medical literature?	
☐ Yes	☐ No
Q11. Does the patient meet all of the following: 1) Hemoglobin less than or equal to 10 g/dL if the patient is not on dialysis, 2) Hemoglobin less than or equal to 11 g/dL for patients on dialysis,3) Has serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20% OR is receiving supplemental iron therapy?	
☐ Yes	☐ No
Q12. Does the patient have anemia while on chemotherapy?	
☐ Yes	☐ No
Q13. Is this a request for continuation of therapy with the requested drug?	
☐ Yes	☐ No
Q14. Does the patient have a pretreatment hemoglobin less than or equal to 10 g/dL?	
☐ Yes	☐ No
Q15. Is the patient currently receiving myelosuppressive chemotherapy and the anticipated outcome is not cure?	
☐ Yes	☐ No
Q16. Has the patient experienced a documented increase in hemoglobin or is prescribed an increased dose of the requested ESA consistent with FDA approved package labeling or peer reviewed medical literature?	
☐ Yes	☐ No
Q17. Does the patient meet all of the following: 1) Hemoglobin less than or equal to 12 g/dL2) Has serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20% OR is receiving supplemental iron therapy?	
☐ Yes	☐ No
Q18. Will the requested drug be used to treat anemia due to zidovudine in beneficiaries with HIV infection?	

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☐ Yes ☐ No

Q19. Is this a request for a continuation of therapy with the requested drug?

☐ Yes ☐ No

Q20. Has the patient experienced a documented increase in hemoglobin or is prescribed an increased dose of the requested ESA consistent with FDA approved package labeling or peer reviewed medical literature?

☐ Yes ☐ No

Q21. Does the patient meet all of the following: 1) Has Hemoglobin less than or equal to 12 g/dL, 2) Has a serum erythropoietin level less than or equal to 500 mUnits/mL, 3) is receiving a dose of zidovudine less than or equal to 4200 mg/week 4) Has serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20% OR is receiving supplemental iron therapy?

☐ Yes ☐ No

Q22. Will the requested drug be used to reduce allogenic blood transfusion in a surgical patient?

☐ Yes ☐ No

Q23. Does the patient meet all of the following: 1) Pretreatment Hemoglobin greater than 10 g/dL but less than or equal to 13 g/d; , 2) Is undergoing elective, non cardiac, non vascular surgery?

☐ Yes ☐ No

Q24. Is the request for a non-preferred product?

☐ Yes ☐ No

Q25. Is this a request for continuation of therapy with the requested drug?

☐ Yes ☐ No

Q26. Has the patient experienced a documented increase in hemoglobin or is prescribed an increased dose of the requested ESA consistent with FDA approved package labeling or peer reviewed medical literature?

☐ Yes ☐ No

Q27. Does the patient meet the following: 1) Has serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20% OR is receiving supplemental iron therapy?

☐ Yes ☐ No

Q28. Does the patient have a documented history of therapeutic failure, contraindication or intolerance of the preferred erythropoiesis stimulation proteins approved or medically accepted for the beneficiary's diagnosis?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q29. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023