



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Antibiotics - Inhaled

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, etc.

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 request for Arikayce, Bethkis, Cayston, Tobi solution, Tobi Podhaler, or tobramycin Pak?

Yes No

Q2. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred inhaled antibiotics approved for the beneficiary's diagnosis?

Yes No

Q3. Does the patient have culture and sensitivity test results that document that only a non-preferred inhaled antibiotic will be effective?

Yes No

Q4. Is this request for tobramycin solution or Kitabis Pak?

Yes No

Q5. 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

Q6. Is the requested product age-appropriate according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q7. 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?

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Patient Name:	Prescriber Name:
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<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q8. Additional Information:
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\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated for 2023*