Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antimalarials

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 requested drug being prescribed for an indication included in the United States Food and Drug Administration (US FDA) approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q2. 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

Q3. Is the requested drug being prescribed for the treatment of malaria?

☐ Yes ☐ No

Q4. Is the requested drug being prescribed for the prevention of malaria?

☐ Yes ☐ No

Q5. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred antimalarial drugs for the patient's diagnosis (e.g., atovaquone/proguanil, chlorquine, Coartem, hydroxychloroquine, Krintafel, mefloquine, primaquine)?

☐ Yes ☐ No

Q6. Additional Information:

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Patient Name:	Prescriber Name:

Prescriber Signature Date

Updated for 2023