



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Bronchodilators - Beta Agonist

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, Strength, Refills, Specialty Pharmacy.

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 a request for a non-preferred oral beta agonist bronchodilator drug?

Yes No

Q2. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred inhaled beta agonist bronchodilators approved or medically accepted for the patient's diagnosis or indication?

Yes No

Q3. Does the patient have a diagnosis of asthma?

Yes No

Q4. Does the patient have a concomitant prescription for an inhaled steroid?

Yes No

Q5. Is this a request for a preferred inhaled long-acting beta agonist bronchodilator drug?

Yes No

Q6. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred long-acting beta agonist bronchodilator drugs?

Yes No

Q7. Is this a request for an inhaled long-acting beta agonist bronchodilator drug when there is a record of a recent paid claim for another drug containing an inhaled long-acting beta agonist (i.e., potential therapeutic duplication)?

Yes No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party.



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Patient Name:	Prescriber Name:
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<p>Q8. Is this a request for a non-preferred inhaled short-acting beta agonist bronchodilator drug?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q9. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred inhaled short-acting beta agonist bronchodilator drugs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q10. Is the patient being titrated to or tapered from a drug in the same class?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q11. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q12. Additional Information:</p>

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated for 2023*