Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Glucocorticoids - 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.

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 this a request for an inhaled glucocorticoid agent when there is a recent paid claim for another agent that contains an inhaled glucocorticoid (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q2. Is the patient being titrated to or tapered from another agent that contains an inhaled glucocorticoid?

☐ Yes ☐ No

Q3. Is the patient being titrated to or tapered from another inhaled long-acting anticholinergic?

☐ Yes ☐ No

Q4. Is the patient being titrated to or tapered from another inhaled long acting beta agonist?

☐ Yes ☐ No

Q5. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q6. Is this a request for a non-preferred single-ingredient inhaled glucocorticoid agent?

☐ Yes ☐ No

Q7. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred single-ingredient inhaled glucocorticoids?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q8. Is this a request for a non-preferred inhaled glucocorticoid combination agent?

☐ Yes ☐ No

Q9. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred inhaled glucocorticoid combination agents?

☐ Yes ☐ No

Q10. Is the request for a formoterol containing glucocorticoid for the treatment of asthma that exceeds the quantity limit guidelines set forth by Health Partners Plans?

☐ Yes ☐ No

Q11. Is the requested formoterol containing glucocorticoid being used as part of treatment guidelines such as SMART therapy AND is the prescribed dose consistent with FDA-approved package labeling or peer reviewed medical literature?

☐ Yes ☐ No

Q12. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023

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