HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Journavx - Non-PDL

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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member 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. The request is for initial treatment with Journavx. If YES, go to 2. If NO, for reauthorization, go to 9.

☐ Yes ☐ No

Q2. The member is 18 years of age or older. If YES, go to 3.

☐ Yes ☐ No

Q3. The member is prescribed Journavx for an indication of moderate to severe acute pain. If YES, go to 4.

☐ Yes ☐ No

Q4. Documentation is attached confirming Journavx will not be used to treat chronic pain. If YES, go to 5.

☐ Yes ☐ No

Q5. Documentation is attached showing that the patient has tried and failed at least two of the following medications within the last 30-days:
a. oral non-steroidal anti-inflammatory drugs (NSAIDs)
b. topical diclofenac sodium gel

Journavx - Non-PDL

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.

Member Name:	Prescriber Name:

c. acetaminophen
d. tramadol
e. opioids
If YES, go to 7. If NO, go to 6.

☐ Yes ☐ No

Q6. If the patient has not tried and failed at least two alternative drugs: documentation showing the patient has a contraindication or intolerance to all the following:
a. oral non-steroidal anti-inflammatory drugs (NSAIDs)
b. topical diclofenac sodium gel
c. acetaminophen
d. tramadol
e. opioids
If YES, go to 7.

☐ Yes ☐ No

Q7. Documentation is attached showing the dose is not to exceed 150 mg (3 tablets) on day 1, then 100 mg (2 tablets) per day. If YES, go to 8.

☐ Yes ☐ No

Q8. Documentation is attached showing the requested treatment duration is for 14 days or less.

☐ Yes ☐ No

Q9. For reauthorization: Documentation is attached showing the patient is experiencing a new episode of moderate to severe acute pain, separate and distinct from the previous episode. If YES, go to 10.

☐ Yes ☐ No

Q10. Documentation is attached showing that the patient has previously had a positive clinical response to therapy.

☐ Yes ☐ No

Q11. Documentation is attached showing the dose is not to exceed 150 mg (3 tablets) on day 1, then 100 mg (2 tablets) per day. If YES, go to 12.

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Journavx - Non-PDL

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.

Member Name:	Prescriber Name:

☐ Yes ☐ No

Q12. Documentation is attached showing the requested treatment duration is for 14 days or less.

☐ Yes ☐ No

Q13. Additional Information:

_____ _____

Prescriber Signature Date

v2025