HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Vijoice - 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. Is this a request for a renewal? If YES, go to 7.

☐ Yes ☐ No

Q2. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of PIK3CA Related Overgrowth Spectrum (PROS) with chart notes attached?

☐ Yes ☐ No

Q4. Are labs attached confirming presence of a mutation in the PIK3CA gene or likely pathogenic variant as confirmed by genetic testing?

☐ Yes ☐ No

Q5. Does the patient have severe manifestations of PROS (e.g., severe vascular malformations, chronic gastrointestinal bleeding, severe dyspnea, disabling chronic pain, severe epilepsy, severe manifestations despite previous debulking surgery, excessive tissue growth, scoliosis, vascular tumors, cardiac or renal manifestations, and those that require systemic treatment)?

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Member Name:	Prescriber Name:

☐ Yes ☐ No

Q6. Is the medication prescribed by, or in consultation with, a physician that specializes in treatment of genetic disorders?

☐ Yes ☐ No

Q7. Is there documentation of positive clinical response to VijoiceTM therapy?

☐ Yes ☐ No

Q8. Is there documentation that the patient has not experienced disease progression while receiving VijoiceTM?

☐ Yes ☐ No

Q9. Is the medication prescribed by, or in consultation with, a physician that specializes in the treatment of genetic disorders?

☐ Yes ☐ No

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2025