

**Brinsupri**
**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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

**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 request for a reauthorization of Brinsupri? If YES, go to 2. If NO, go to 5.

 Yes

 No

Q2. The member has a diagnosis of non-cystic fibrosis bronchiectasis (NCFB).

 Yes

 No

Q3. The drug is being prescribed by or in consultation with a pulmonologist or infectious disease specialist.

 Yes

 No

Q4. The patient has experienced a positive response to therapy (e.g., reduction in pulmonary exacerbations from baseline).

 Yes

 No

Q5. The member is 12 years of age or older.

 Yes

 No

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Member Name:	Prescriber Name:
Q6. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. The member has a documented diagnosis of non-cystic fibrosis bronchiectasis (NCFB) confirmed by a chest computed tomography (CT) scan. Attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. The member has a documented clinical history consistent with bronchiectasis (chronic cough, chronic sputum production, and/or recurrent RTIs). Attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. The member has documentation of one of the following (attach documentation): <input type="checkbox"/> a. For 18 years of age and older, the member has experienced at least two (2) exacerbations in the previous 12 months that led to antibiotic treatment <input type="checkbox"/> b. For 12 years of age to less than 18 years of age, the member has had at least one (1) pulmonary exacerbation in the previous 12 months that led to antibiotic treatment	
Q10. The drug is being prescribed by or in consultation with a pulmonologist or infectious disease specialist. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Additional Information:	

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

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