**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.**

| | | |
|---|---|---|
| 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. For a non-preferred single-ingredient Glucocorticoid, Inhaled (i.e., a product that contains only one active ingredient), has history of therapeutic failure of or a contraindication or an intolerance to the preferred single-ingredient Glucocorticoids, Inhaled approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q2. For a non-preferred Glucocorticoid, Inhaled combination agent (i.e., a product that contains more than one active ingredient), has history of therapeutic failure of or a contraindication or an intolerance to the preferred Glucocorticoid, Inhaled combination agents approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q3. If a prescription for a Glucocorticoid, Inhaled containing a beta agonist for the treatment of asthma, is for a quantity that exceeds the quantity limit, the beneficiary is using the requested drug as part of a therapy that is supported by consensus treatment guidelines (e.g., Single Maintenance and Reliever Therapy [SMART]).

☐ Yes ☐ No

Q4. The prescribed dose is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

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| Member Name: | Prescriber Name: |
|---|---|

| ☐ Yes | ☐ No |
|---|---|
| Q5. Additional Information: | |

Prescriber Signature _____ Date _____

*v2026*