



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Strensiq - 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: <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 this a request for continuation of therapy? If YES, go to 8. If NO, go to 2.

Yes No

Q2. Does the patient have a diagnosis of perinatal/infantile-onset or juvenile-onset hypophosphatasia?

Yes No

Q3. Did the onset of disease occur prior to age of 18 years?

Yes No

Q4. Are there clinical signs and symptoms of hypophosphatasia, applicable labs and/or tests provided supporting the diagnosis? Examples include: X-rays results showing fractures, skeletal abnormalities, premature loss of deciduous teeth, bone loss or respiratory problems, vitamin B6-dependent seizures, failure to thrive, delayed walking, waddling gait, labs showing low blood levels of alkaline phosphatase activity, elevated levels of phosphoethanolamine and pyridoxal 5'-phosphate and mutations in the gene encoding tissue nonspecific alkaline phosphatase (TNSALP).

Yes No

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Member Name:	Prescriber Name:
<p>Q5. Is the medication prescribed by (or in consultation with) an endocrinologist or a prescriber specializing in inherited metabolic disorders?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q6. Has the patient been appropriately evaluated and confirmation the patient does not have a treatable form of rickets, current exposure to a bisphosphonate, hypocalcemia, hypophosphatemia or a serum 25-Hydroxyvitamin D level of less than 20 ng/mL?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q7. Is the requested dose within the Food and Drug Administration (FDA) labeled dosing guidelines (patient's weight must be provided)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q8. Has documentation of clinical benefit been provided, as shown by improvement in any of the following: clinical symptoms, radiographic findings, respiratory assessments, pulmonary function testing, growth parameters, mobility, pain assessments?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q9. Has documentation of ophthalmic and renal monitoring (concern for ophthalmic or renal ectopic calcifications) been provided?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q10. Is the requested dose within the FDA labeled dosing guidelines (patient's weight must be provided)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q11. Additional Information:</p>	

 Prescriber Signature

 Date



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Prescriber Name:

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