HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Proton Pump Inhibitors

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 member is prescribed the requested PPI for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication.

☐ Yes ☐ No

Q2. The member is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q3. For a non-preferred PPI, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred PPIs.

☐ Yes ☐ No

Q4. For a child under six years of age when a PPI has been prescribed for a total of four months or more in the preceding 180-day period, one of the following:

☐ Has a chronic primary disease such as cystic fibrosis, cerebral palsy, Down syndrome, intellectual disability, or repaired esophageal atresia

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Member Name:	Prescriber Name:

☐ Has documentation of a comprehensive evaluation and appropriate diagnostic testing confirming a diagnosis that requires chronic therapy

☐ Is being prescribed the requested drug by or in consultation with a gastroenterologist

Q5. For an OTC PPI for a dual-eligible beneficiary, both of the following:

☐ a. Is not being prescribed the OTC PPI as part of a Medicare Part D plan utilization management program, including a step-therapy or prior authorization program

☐ b. Has a history of therapeutic failure of or a contraindication or an intolerance to the PPIs on the beneficiary's Medicare Part D plan formulary.

Q6. Additional Information:

Prescriber Signature

Date

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