HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Ulcerative Colitis Agents

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 request is for an Ulcerative Colitis Agent that was previously approved. If YES, go to 8.

☐ Yes ☐ No

Q2. For an S1PR modulator, for treatment of multiple sclerosis, see the prior authorization guideline related to Multiple Sclerosis Agents

☐ Yes ☐ No

Q3. For treatment of ulcerative colitis (UC), the member meets ALL of the following:

☐ Is prescribed the requested drug 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

☐ Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Is prescribed a dose that is consistent with the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Is prescribed the requested drug by or in consultation with an appropriate specialist (e.g., a gastroenterologist)

☐ Does not have a contraindication to the requested drug

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Member Name:	Prescriber Name:

Q4. The member has ONE of the following:

☐ A diagnosis of moderate to severe UC
☐ A diagnosis of mild UC that is associated with multiple poor prognostic factors
☐ Has achieved remission with the requested drug OR will be using the requested drug as maintenance therapy to maintain remission

Q5. The member meets ONE of the following:

☐ Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Cytokine and CAM Antagonists approved or medically accepted for treatment of ulcerative colitis

☐ Has a current history (within the past 90 days) of being prescribed an S1PR modulator

Q6. For a non-preferred S1PR modulator, ONE of the following:

☐ Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred S1PR modulators approved or medically accepted for treatment of ulcerative colitis

☐ Has a current history (within the past 90 days) of being prescribed the same S1PR modulator (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred)

Q7. For all other non-preferred Ulcerative Colitis Agents, ONE of the following:

☐ Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Ulcerative Colitis Agents approved or medically accepted for the beneficiary's diagnosis

☐ Has a current history (within the past 90 days) of being prescribed the same non-preferred Ulcerative Colitis Agent (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred)

Q8. The member meets ALL of the following:

☐ The member experienced improvement in disease activity and/or level of functioning since starting the requested drug.

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Member Name:	Prescriber Name:

☐ Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Is prescribed the requested drug by or in consultation with an appropriate specialist (e.g., gastroenterologist)

☐ Does not have a contraindication to the requested drug

Q9. For a non-preferred S1PR modulator with a therapeutically equivalent brand or generic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested drug.

☐ Yes ☐ No

Q10. Additional Information:

Prescriber Signature

Date

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