

Health Partners Plans

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Nonsteroidal Anti-Inflammatory Drugs (NSAIDS)

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, dr	ug, labs) leπ blank, illegible, or no	of attached WILL DELAY the review process.	
Patient Name:	e: Prescriber Name:		
HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Patient 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:	<u> </u>		
Diagnosis Code: Diagn	osis:		
HPP's maximum approval time i		pending on the drug.	
Please attach any pertinent medical history include	ling labs and information for t	his mambar that may support approval	
	the following questions and s		
	are ronowing questions and s	ngn.	
Q1. Is this a request for oral or nasal ketorolac?			
Yes	□ No		
Q2. Is the requested drug age-appropriate according compendia, or peer-reviewed medical literature?	ng to FDA-approved package	e labeling, nationally recognized	
Yes	☐ No		
Q3. Is the patient prescribed a dose and duration of nationally recognized compendia, or peer-reviewed		ith FDA-approved package labeling,	
☐ Yes ☐ No			
Q4. Is the patient taking aspirin or any other nonste	eroidal anti-inflammatory drug	gs (NSAIDs) concurrently?	
☐ Yes ☐ No			
Q5. Is this a request for a non-preferred oral nonst	eroidal anti-inflammatory drug	g (NSAID)?	
Yes	☐ No		
Q6. Does the patient have a documented history or preferred NSAIDs (excluding ketorolac) with the sa		dication to, or intolerance of the oral	
☐ Yes	☐ No		
Q7. Is this a request for non-preferred topical NSA	ID?		
☐Yes	☐ No		

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Patient Name:	Prescriber Name:	
Q8. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the topical preferred NSAIDs?		
☐ Yes	□ No	
Q9. Is this a request for a non-preferred nasal ketorolac?		
☐ Yes	□ No	
Q10. Does the patient have a clinical reason as documented by the prescriber why oral ketorolac cannot be used?		
☐ Yes	□ No	
Q11. Is this a request for any other non-preferred non-oral nonsteroidal anti-inflammatory drug (NSAID)?		
☐ Yes	□ No	
Q12. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to the preferred NSAIDs?		
☐ Yes	□ No	
Q13. Does the patient have a clinical reason as documented by the prescriber why the routes of administration of the preferred NSAIDs cannot be used?		
☐ Yes	□ No	
Q14. Is this a request for a non-preferred NSAID combination drug with more than one active ingredient (e.g., Duexis, Vimovo, etc.)?		
☐ Yes	□ No	
Q15. Does the patient have a clinical reason as documented by the prescriber why the individual active ingredients cannot be used concurrently?		
☐ Yes	□ No	
Q16. Is this a request for an NSAID when there is a recor therapeutic duplication)?	rd of a recent paid claim for another NSAID (i.e., potential	
☐ Yes	□ No	
Q17. Is the patient being transitioned to another drug in the same class with the intent of discontinuing one of the medications?		
☐ Yes	□ No	
Q18. Has the prescriber provided a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?		
Yes	□ No	

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Patient Name:	Prescriber Name:
Q19. Additional Information:	
Prescriber Signature	Date

Updated for 2023