Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Rebif (Interferon Beta)

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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

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. Is the patient over the age of 18?
☐ Yes ☐ No

Q2. Is the prescriber a neurologist or in consultation with a neurologist?
☐ Yes ☐ No

Q3. Does the patient have a diagnosis of relapsing forms of multiple sclerosis?
☐ Yes ☐ No

Q4. Has the patient experienced a first clinical episode and have MRI features consistent with multiple sclerosis?
☐ Yes ☐ No

Q5. Is the patient currently stabilized on Rebif therapy?
☐ Yes ☐ No

Q6. Has the patient had a trial or is intolerant to Glatopa® , Gilenya® , Tecfidera®, Aubagio®, Avonex® and Copaxone®?
☐ Yes ☐ No

Q7. Requested Duration:

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Patient Name:	**Prescriber Name:**

☐ 12 Months
Q8. Additional Information:

Prescriber Signature _____ Date _____

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