



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with two columns: Patient Name and Prescriber Name. Fields include HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Fax, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, and Specialty/facility name (if applicable).

Expedited/Urgent checkbox

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 checkbox

No checkbox

Q2. Is the prescriber a neurologist or in consultation with a neurologist?

Yes checkbox

No checkbox

Q3. Does the patient have a diagnosis of relapsing forms of multiple sclerosis?

Yes checkbox

No checkbox

Q4. Has the patient experienced a first clinical episode and have MRI features consistent with multiple sclerosis?

Yes checkbox

No checkbox

Q5. Is the patient currently stabilized on Rebif therapy?

Yes checkbox

No checkbox

Q6. Has the patient had a trial or is intolerant to Glatopa®, Gilenya®, Tecfidera®, Aubagio®, Avonex® and Copaxone®?

Yes checkbox

No checkbox

Q7. Requested Duration:

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**Patient Name:**

**Prescriber Name:**

12 Months

Q8. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated 2018*