Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Tecfidera

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 medication prescribed by or in consultation with a neurologist?
☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?
☐ Yes ☐ No

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

Q4. Does the member have one of the following conditions? A. Lymphopenia B. Severe and/or uncontrolled infections
☐ Yes ☐ No

Q5. Are the following labs attached and within normal limits? A. CBC with lymphocyte count (obtained within 6 months prior to use) B. Liver function tests (serum AST/ALT, alkaline phosphatase, and total bilirubin)
☐ Yes ☐ No

Q6. Will the following parameters be monitored periodically? A. CBC with lymphocyte count (obtained within 6 months prior to use, then at least annually during therapy or as clinically necessary) B. Liver function tests (serum AST/ALT, alkaline phosphatase, and total bilirubin)
☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q7. Requested Duration:

☐ 12 Months

Q8. Additional Information:

Prescriber Signature

Date

Updated 2018