



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields for Patient Name, HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Prescriber Name, Fax, Phone, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, 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 medication prescribed by or in consultation with a neurologist?

Yes checkbox

No checkbox

Q2. Is the patient 18 years of age or older?

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q4. Does the member have one of the following conditions? A. Lymphopenia B. Severe and/or uncontrolled infections

Yes checkbox

No checkbox

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 checkbox

No checkbox

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 checkbox

No checkbox

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Patient Name:

Prescriber Name:

Q7. Requested Duration:

12 Months

Q8. Additional Information:

Prescriber Signature

Date

Updated 2018