



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Opsumit (macitentan)

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 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 prescribing physician a Cardiologist or Pulmonologist?

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q3. Is the member female or male?

Male checkbox

Female checkbox

Q4. If female, is the member enrolled in the Opsumit REMS program?

Yes checkbox

No checkbox

Q5. If female, is she pregnant?

Yes checkbox

No checkbox

Q6. Is she able to get pregnant?

Yes checkbox

No checkbox

Q7. Will the member (female) use reliable forms of contraception?

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Opsumit (macitentan)

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, Prescriber Name, and questions Q8-Q14 regarding pregnancy tests, WHO Group 1 PAH diagnosis, RHC confirmation, NYHA Functional Class, hemoglobin/hematocrit levels, and requested duration.

Prescriber Signature

Date

Updated 2018