Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Opsumit (macitentan) Renewal

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. Has the member tolerated the medication without any significant side effects?
☐ Yes ☐ No

Q2. Is the member compliant with therapy?
☐ Yes ☐ No

Q3. Is the member a female of child-bearing potential?
☐ Yes ☐ No

Q4. Has the pregnancy test attached?
☐ Yes ☐ No

Q5. Is the member pregnant?
☐ Yes ☐ No

Q6. Has the member met his/her treatment goals? Please refer to the following:A.Symptom improvement B.Lowering PAP (pulmonary artery pressure)C.Reverse/prevent progression
☐ Yes ☐ No

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Opsumit (macitentan) Renewal

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:**

Q7. Has the hemoglobin/hematocrit levels and liver enzymes (baseline, at 1 month, and periodically thereafter) attached?

☐ Yes ☐ No

Q8. Requested Duration:

☐ 6 months

Q9. Additional Information:

Prescriber Signature

Date

Updated 2018