



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Simponi

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 patient 18 years of age or older?

Yes checkbox

No checkbox

Q2. Does the patient have a diagnosis of moderate to severe active rheumatoid arthritis (RA), active psoriatic arthritis (PsA), or active ankylosing spondylitis (AS)?

Yes checkbox

No checkbox

Q3. Is the prescribing physician a rheumatologist, dermatologist or in consultation with a rheumatologist or dermatologist (in case of psoriasis)?

Yes checkbox

No checkbox

Q4. For rheumatoid arthritis (RA) or psoriatic arthritis (PsA): Has the patient failed or had an inadequate response to the trial of at least one or more DMARD OR is intolerant to DMARDs [e.g., Imuran® (azathioprine), Ridaura® (oral gold), Plaquenil® (hydroxychloroquine), Cuprimine® (D-penicillamine), Azulfidine® (sulfasalazine), methotrexate and NSAIDs]?

Yes checkbox

No checkbox

Q5. For ankylosing spondylitis (AS): Has the patient failed or had an inadequate response to the trial of at least one or more DMARD or is intolerant to DMARDs [e.g., NSAIDs, Azulfidine® (sulfasalazine), methotrexate]?

Yes checkbox

No checkbox

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Patient Name:

Prescriber Name:

Q6. Has the patient failed or had an inadequate response to Enbrel® and Humira® or is there any contraindication for patient to try Enbrel® and Humira®?

Yes checkbox

No checkbox

Q7. Does the patient have a diagnosis of moderately to severely active ulcerative colitis (UC) with an inadequate response or intolerance to previous treatment (such as azathioprine or 6-mercaptopurine (6-MP)) or requiring continued steroid therapy?

Yes checkbox

No checkbox

Q8. Is the prescribing physician a gastroenterologist or in consultation with a gastroenterologist?

Yes checkbox

No checkbox

Q9. Has the patient had inadequate response or been intolerant to Humira® or is there any contraindication for patient to try Humira® ?

Yes checkbox

No checkbox

Q10. Has patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy?

Yes checkbox

No checkbox

Q11. Is the tuberculin skin test negative?

Yes checkbox

No checkbox

Q12. If latent infection is diagnosed, has the patient received appropriate prophylaxis in accordance with the CDC and prevention guidelines should be instituted?

Yes checkbox

No checkbox

Q13. Is the patient being treated for any other active infection?

Yes checkbox

No checkbox

Q14. Requested Duration:

12 Months checkbox

Q15. Additional Information:

Prescriber Signature

Date

Updated 2018

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