Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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 patient 18 years of age or older?

☐ Yes ☐ No

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 ☐ No

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

☐ Yes ☐ No

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 ☐ No

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, Azulfudine® (sulfasalazine), methotrexate]?

☐ Yes ☐ No

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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 ☐ No

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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Q11. Is the tuberculin skin test negative?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Q14. Requested Duration:

☐ 12 Months

Q15. Additional Information:

Prescriber Signature

Date

Updated 2018