



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Gilenya 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.

Form with two columns: Patient Name and Prescriber Name. Fields include Member Number, Date of Birth, Address, Phone, Fax, Office Contact, NPI, Promise ID, etc.

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. Has the patient been compliant with GILENYA therapy?

Yes/No checkboxes

Q2. Does the patient have an acute or chronic infection?

Yes/No checkboxes

Q3. Are post-treatment lab results (e.g. CBC, FEV1, DLCO, bilirubin and liver transaminases) attached with results within normal range?

Yes/No checkboxes

Q4. Has the patient received a post-treatment ophthalmologic evaluation with results that show no signs and symptoms of macular edema? (Documentation must be attached.)

Yes/No checkboxes

Q5. Is the dose and frequency of treatment prescribed within medically accepted guidelines for use and does not exceed 0.5 mg once daily for patients 10 years and older weighing greater than 40 kg OR 0.25 mg once daily for patients 10 years and older weighing less than or equal to 40 kg?

Yes/No checkboxes

Q6. Requested Duration:

12 Months checkbox

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**Patient Name:**

**Prescriber Name:**

Q7. Additional Information:

Prescriber Signature

Date

*Updated 2018*