HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Pulmozyme

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 Pulmozyme being prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of cystic fibrosis? (please attach documentation of diagnosis).

☐ Yes ☐ No

Q3. Is Pulmozyme being prescribed in conjunction with standard therapies (such as disease-modifying (potentiator) drug, oral, inhaled and/or parenteral antibiotics, bronchodilators, pancreatic enzyme supplements, vitamins, oral or inhaled corticosteroids, inhaled hypertonic saline, analgesics, and chest physiotherapy) for cystic fibrosis?

☐ Yes ☐ No

Q4. Will Pulmozyme be administered using a recommended jet nebulizer/compressor system or eRapid Nebulizer System?

☐ Yes ☐ No

Q5. Is Pulmozyme being prescribed at a dose of 2.5 mg once daily (any request for twice daily Pulmozyme will require documentation of an adequate trial of once daily dosing consisting of at least a 2 week trial)?

☐ Yes ☐ No

Q6. Requested Duration:

☐ 6 Months

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Patient Name:	**Prescriber Name:**

Q7. Additional Information:

Prescriber Signature

Date

Updated 2018

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