



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Erythropoiesis Stimulating Agents (ESAs)

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 medication being used for a diagnosis that is indicated in the FDA-approved package insert? Please provide chart notes documenting the diagnosis.

Yes checkbox

No checkbox

Q2. Is the medication being used for a diagnosis that is listed in nationally recognized compendia for the determination of medically-accepted indications? Please provide chart notes documenting the diagnosis.

Yes checkbox

No checkbox

Q3. Have lab work (hemoglobin, iron stores) been obtained per recommendations related to specified diagnosis? (please attach a copy of the lab result)

Yes checkbox

No checkbox

Q4. Has the patient tried and failed, or has a contraindication or intolerance to oral iron (such as ferrous sulfate) or intravenous iron if applicable to diagnosis? (Please include documentation of agents used, with dose/strength, dates/duration of use, and specific outcomes.)

Yes checkbox

No checkbox

Q5. Has the patient tried and failed Retacrit, as applicable per indication? (Please include documentation of agent(s) used, with doses, dates/duration of use, and specific outcomes)

Yes checkbox

No checkbox

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Patient Name:

Prescriber Name:

Q6. Is the request for Retacrit and dosed appropriately based on patients diagnosis and age?

Yes

No

Q7. Is the request for Procrit and dosed appropriately based on patient's diagnosis and age (Please include weight and rationale behind dosing schedule)?

Yes

No

Q8. Will lab work (hemoglobin, iron stores) be monitored periodically based on diagnosis?

Yes

No

Q9. Requested Duration:

3 Months

Q10. Additional Information:

Prescriber Signature

Date

Updated 2018