Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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

☐ Yes ☐ No

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 ☐ No

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

☐ Yes ☐ No

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 ☐ No

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 ☐ No

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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