Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Strensiq

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. Does the patient have a diagnosis of perinatal/infantile-onset or juvenile-onset hypophosphatasia?

☐ Yes ☐ No

Q2. Did the onset of disease occur prior to age of 18 years?

☐ Yes ☐ No

Q3. Are applicable labs and/or tests provided supporting the diagnosis? Labs/tests include: X-rays results showing fractures, skeletal abnormalities, premature loss of deciduous teeth, bone loss or respiratory problems, labs showing low blood levels of alkaline phosphatase activity, elevated levels of phosphoethanolamine and pyridoxal 5'-phosphate and mutations in the gene encoding tissue nonspecific alkaline phosphatase (TNSALP).

☐ Yes ☐ No

Q4. Is the medication prescribed by (or in consultation with) an endocrinologist or a prescriber specializing in inherited metabolic disorders?

☐ Yes ☐ No

Q5. Has the member been appropriately evaluated and confirmation the member does not have a treatable form of rickets, current exposure to a bisphosphonate, hypocalcemia, hypophosphatemia or a serum 25-Hydroxyvitamin D level of less than 20 ng/mL?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Is the requested dose within the FDA labeled dosing guidelines (patient's weight must be provided)?

☐ Yes ☐ No

Q7. Requested Duration:

☐ 6 months

Q8. Additional Information:

Prescriber Signature

Date

Updated 2018