



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

FILGRASTIM AGENTS

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, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Fax, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, and 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 packet 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 a CBC (complete blood count with differential) and platelet count been obtained? (please attach a copy of the lab result)

Yes checkbox

No checkbox

Q4. Has the patient tried and failed Zarxio and/or Nivestym, as applicable per indication? (Please include documentation of agent(s) used, with doses, dates/duration of use, and specific outcomes)

Yes checkbox

No checkbox

Q5. Is the request for Zarxio or Nivestym and dosed appropriately based on patients diagnosis and age?

Yes checkbox

No checkbox

Q6. Is the request for Neupogen and dosed appropriately based on patient's diagnosis and age?

Yes checkbox

No checkbox

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Patient Name:

Prescriber Name:

Q7. Will CBC (complete blood count with differential) and platelet count be monitored periodically based on diagnosis?

Yes

No

Q8. Requested Duration:

3 Months

Q9. Additional Information:

Prescriber Signature

Date

*Updated 2018*