Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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 packet 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 a CBC (complete blood count with differential) and platelet count been obtained? (please attach a copy of the lab result

☐ Yes ☐ No

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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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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