



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Valcyte

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, Office Contact, NPI, Address, City, State ZIP, Specialty/facility name, Promise ID, and Prescriber PA PROMISE ID.

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. Does the patient have ALL of the following lab parameters met? (Labs must be attached). a.Absolute neutrophil count greater than 500 cells/µL; b.Platelet count greater than 25,000/µL; c.Hemoglobin greater than 8 g/dL; d.Creatinine clearance greater than 10 mL/min

Yes checkbox

No checkbox

Q2. Is valganciclovir being prescribed for the prevention of CMV disease in a pediatric kidney transplant patient 4 months to 16 years of age at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-])? (Please provide documentation of CMV donor and recipient status.)

Yes checkbox

No checkbox

Q3. Has the dose been adjusted for body surface area (BSA) and renal function (Schwartz creatinine clearance)?

Yes checkbox

No checkbox

Q4. Is valganciclovir being prescribed for the prevention of CMV disease in a pediatric heart transplant patient 1 month to 16 years of age at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-])? (Please provide documentation of CMV donor and recipient status.)

Yes checkbox

No checkbox

Q5. Has the dose been adjusted for body surface area (BSA) and renal function (Schwartz creatinine clearance)?

Yes checkbox

No checkbox

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Patient Name:

Prescriber Name:

Q6. Is valganciclovir being prescribed for the prevention of CMV disease in an adult heart OR kidney-pancreas transplant patient at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-])? (Please provide documentation of CMV donor and recipient status.)

Yes checkbox

No checkbox

Q7. Does the dose require adjustment based on renal function?

Yes checkbox

No checkbox

Q8. Has the dose been adjusted based on the patient's creatinine clearance? (Please provide titration schedule for increasing the dose as tolerated).

Yes checkbox

No checkbox

Q9. Is valganciclovir being prescribed for the prevention of CMV disease in an adult kidney transplant patient at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-])? (Please provide documentation of CMV donor and recipient status.)

Yes checkbox

No checkbox

Q10. Does the dose require adjustment based on renal function?

Yes checkbox

No checkbox

Q11. Has the dose been adjusted based on the patient's creatinine clearance? (Please provide titration schedule for increasing the dose as tolerated).

Yes checkbox

No checkbox

Q12. Is valganciclovir being prescribed for CMV retinitis in a patient with AIDS? (Please provide documentation.)

Yes checkbox

No checkbox

Q13. Does the patient have active retinitis?

Yes checkbox

No checkbox

Q14. Requested Duration:

21 days checkbox

100 days checkbox

200 days checkbox

Q15. Additional Information:

Prescriber Signature

Date

Updated 2018

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