Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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 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 ☐ No

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 ☐ No

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

☐ Yes ☐ No

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 ☐ No

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

☐ Yes ☐ No

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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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Q13. Does the patient have active retinitis?

☐ Yes ☐ No

Q14. Requested Duration:

☐ 21 days ☐ 100 days ☐ 200 days

Q15. Additional Information:

Prescriber Signature

Date

Updated 2018