



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Palynziq Renewal

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. Has the patient been approved for treatment with Palynziq previously?

Yes checkbox

No checkbox

Q2. Has the patient been compliant with filling their prescription?

Yes checkbox

No checkbox

Q3. Has the patient experienced any serious side effects (such as anaphylactic events) while being treated with Palynziq?

Yes checkbox

No checkbox

Q4. Has the patient had at least a 20% reduction in blood phenylalanine concentration that is less than or equal to 600 micromol/L after 16 weeks of continuous treatment with the maximum dosage of 40 mg subcutaneously once daily (if applicable)? Labs must be attached.

Yes checkbox

No checkbox

Q5. Requested Duration:

6 months checkbox

Q6. Additional Information:

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

Palynziq Renewal

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:

Prescriber Signature

Date

Updated 2018