



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Bosentan 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 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, Phone, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, 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 tolerated the medication without any significant side effects?

Yes checkbox

No checkbox

Q2. Is the patient compliant with therapy?

Yes checkbox

No checkbox

Q3. Is the patient a female of child-bearing potential?

Yes checkbox

No checkbox

Q4. Is the pregnancy test attached?

Yes checkbox

No checkbox

Q5. Is the patient pregnant?

Yes checkbox

No checkbox

Q6. Has the patient met his/her treatment goals: • Symptom improvement; • Lowering PAP (pulmonary artery pressure); • Reverse/prevent progression?

Yes checkbox

No checkbox

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

Bosentan 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:

Q7. Have the following lab results been attached: • ALT/AST and bilirubin (monthly); • Hemoglobin and hematocrit (after 1 and 3 months of treatment, then every 3 months thereafter)?

Yes

No

Q8. Duration:

6 months

Q9. Additional Information:

Prescriber Signature

Date

Updated 2018