Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antibiotics - Inhaled

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:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
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 this request for Arikayce, Bethkis, Cayston, Tobi solution, Tobi Podhaler, or tobramycin Pak?

☐ Yes ☐ No

Q2. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred inhaled antibiotics approved for the beneficiary's diagnosis?

☐ Yes ☐ No

Q3. Does the patient have culture and sensitivity test results that document that only a non-preferred inhaled antibiotic will be effective?

☐ Yes ☐ No

Q4. Is this request for tobramycin solution or Kitabis Pak?

☐ Yes ☐ No

Q5. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q6. Is the requested product age-appropriate according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q7. Is the patient prescribed a dose and duration of therapy that is consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2020