Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Anticoagulants

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 the patient being 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?

☐ Yes ☐ No

Q2. Does the patient have a history of a contraindication to the requested drug?

☐ Yes ☐ No

Q3. Is this a request for an oral or injectable anticoagulant when there is a record of a recently paid claim for another anticoagulant with the same route of administration (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q4. Is the patient being titrated to or tapered from another anticoagulant with the same route of administration as the requested drug?

☐ Yes ☐ No

Q5. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q6. Is this a request for a preferred anticoagulant drug?

☐ Yes ☐ No

Q7. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred anticoagulant drugs approved or medically accepted for the patient's diagnosis or indication?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2020