Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Beta Blockers

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 a request for Hemangeol (propranolol hydrochloride oral solution)?

☐ Yes ☐ No

Q2. Is the requested drug being prescribed by or in consultation with an appropriate specialist (e.g., pediatric dermatologist, hematologist, or oncologist)?

☐ Yes ☐ No

Q3. 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?

☐ Yes ☐ No

Q4. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q5. Does the patient have documentation of improvement in disease severity since initiating treatment with the requested drug?

☐ Yes ☐ No

Q6. Is the requested drug prescribed for an indication that is included in the Food and Drug Administration (FDA) approved package labeling?

☐ Yes ☐ No

Q7. Is the requested drug age-appropriate for the patient according to 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. Is this a request for a beta blocker drug when there is a record of a recent paid claim for another beta blocker (i.e., potential therapeutic duplication)?	
☐ Yes	☐ No
Q9. Is the patient being titrated to, or tapered from, a drug in the same class?	
☐ Yes	☐ No
Q10. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?	
☐ Yes	☐ No
Q11. Is this a request for a preferred beta blocker drug (e.g., acebutolol, atenolol, atenolol/chlorthalidone, bisoprolol, bisoprolol/hydrochlorothiazide, carvedilol, Hemangeol, labetalol tablet, metoprolol succinate extended-release, metoprolol tartrate tablet, pindolol, propranolol tablet, propranolol oral solution, propranolol extended-release, propranolol/hydrochlorothiazide, sotalol, sotalol AF)?	
☐ Yes	☐ No
Q12. Does the patient have a documented history of therapeutic failure, intolerance of, or contraindication to the preferred beta blocker drugs approved or medically accepted for the patient's diagnosis (e.g., acebutolol, atenolol, atenolol/chlorthalidone, bisoprolol, bisoprolol/hydrochlorothiazide, carvedilol, Hemangeol, labetalol tablet, metoprolol succinate extended-release, metoprolol tartrate tablet, pindolol, propranolol tablet, propranolol oral solution, propranolol extended-release, propranolol/hydrochlorothiazide, sotalol, sotalol AF)?	
☐ Yes	☐ No
Q13. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2020