



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Bronchodilators - Beta Agonist

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: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, Strength, Refills, Specialty Pharmacy.

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 a non-preferred oral beta agonist bronchodilator drug?

Yes No

Q2. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred inhaled beta agonist bronchodilators approved or medically accepted for the patient's diagnosis or indication?

Yes No

Q3. Is this a request for a single ingredient long-acting inhaled beta agonist bronchodilator drug?

Yes No

Q4. Does the patient have a diagnosis of asthma?

Yes No

Q5. Does the patient have a concomitant prescription for an inhaled steroid?

Yes No

Q6. Is this a request for a preferred inhaled long-acting beta agonist bronchodilator drug?

Yes No

Q7. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred long-acting beta agonist bronchodilator drugs?

Yes No



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Patient Name: Prescriber Name:

Q8. Is this a request for an inhaled long-acting beta agonist bronchodilator drug when there is a record of a recent paid claim for another drug containing an inhaled long-acting beta agonist (i.e., potential therapeutic duplication)?
Q9. Is this a request for a preferred inhaled short-acting beta agonist bronchodilator drug?
Q10. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred inhaled short-acting beta agonist bronchodilator drugs?
Q11. Is this a request for an inhaled short-acting beta agonist bronchodilator drug when there is a record of a recent paid claim for another drug containing an inhaled short-acting beta agonist (i.e., potential therapeutic duplication)?
Q12. Is the patient being titrated to or tapered from a drug in the same class?
Q13. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?
Q14. Additional Information:

Prescriber Signature

Date

Updated for 2020