



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Colony Stimulating Factors

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 two columns: Patient Name and Prescriber Name. Fields include HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Fax, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, and Specialty/facility name (if applicable).

Expedited/Urgent

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. Is the requested drug prescribed for either of the following: A) an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling, or B) a medically accepted indication?

Yes checkbox

No checkbox

Q2. Is the requested drug age-appropriate according to the U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q3. Is the requested drug prescribed by or in consultation with a hematologist or oncologist?

Yes checkbox

No checkbox

Q4. Does the patient have a history of a contraindication to the prescribed drug?

Yes checkbox

No checkbox

Q5. Is the requested drug prescribed for primary prophylaxis of chemotherapy-induced febrile neutropenia in a patient with non-myeloid malignancy?

Yes checkbox

No checkbox

Q6. Will the patient be receiving a chemotherapy regimen with an expected incidence of febrile neutropenia greater than 20 percent as defined by the National Comprehensive Cancer Network (NCCN)?

Yes checkbox

No checkbox

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Patient Name:

Prescriber Name:

Q7. Does the patient have risk factors for developing febrile neutropenia as defined by the National Comprehensive Cancer Network (NCCN)?

Yes

No

Q8. Is the requested drug Neulasta (pegfilgrastim)?

Yes

No

Q9. Will the patient be receiving the medication during the period beginning 14 days before and ending 24 hours after administration of cytotoxic chemotherapy?

Yes

No

Q10. Is the request for a non-preferred colony stimulating factor product?
[Note: See the Preferred Drug List (PDL) for the list of preferred Colony Stimulating Factors at: <https://papdl.com/preferred-drug-list>]

Yes

No

Q11. Does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred colony stimulating factors?

Yes

No

Q12. Additional Information:

Prescriber Signature

Date

Updated for 2020