Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	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 ether 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 ☐ No

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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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 ☐ No

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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