Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Idiopathic Pulmonary Fibrosis Agents

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 request for renewal of therapy (i.e., The requested drug has been previously approved on prior authorization)?
[If yes, skip to question 25.]

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of idiopathic pulmonary fibrosis (IPF)?

☐ Yes ☐ No

Q3. Have other known causes of interstitial lung disease (ILD) and dyspnea been excluded?

☐ Yes ☐ No

Q4. Does a high-resolution computed tomography (HRCT) scan show the presence of a usual interstitial pneumonia (UIP) pattern revealing idiopathic pulmonary fibrosis (IPF) or probable IPF?

☐ Yes ☐ No

Q5. Has a surgical lung biopsy pattern and high-resolution computed tomography (HRCT) scan revealed idiopathic pulmonary fibrosis (IPF) or probable IPF?

☐ Yes ☐ No

Q6. Is the patient age-appropriate according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q7. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally

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recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q8. Is the requested drug prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

Q9. Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug or counseling of the beneficiary of the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

Q10. Have baseline liver function tests been performed (alanine aminotransferase [ALT], aspartate aminotransferase [AST], bilirubin)? Note: Please attach test results.

☐ Yes ☐ No

Q11. Does the patient currently smoke?

☐ Yes ☐ No

Q12. Is the request for Esbriet?

☐ Yes ☐ No

Q13. Does the patient have end-stage renal disease requiring dialysis?

☐ Yes ☐ No

Q14. Will the patient have liver function tests completed every month for the first 6 months and then every 3 months thereafter?

☐ Yes ☐ No

Q15. Is the request for Ofev?
[If no, skip to question 22.]

☐ Yes ☐ No

Q16. Does the patient have any of the following: A) Severe renal impairment or end-stage renal disease, B) Alanine aminotransferase (ALT), aspartate aminotransferase (AST) or bilirubin greater than 1.5 times the upper limit of normal, C) Active bleeding, D) A recent history of myocardial infarction or stroke, E) Gastrointestinal perforation?

☐ Yes ☐ No

Q17. Will the patient have liver function tests completed every month for the first 3 months and then every 3 months thereafter?

☐ Yes ☐ No

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Q18. Is the patient taking anticoagulation therapy?

☐ Yes ☐ No

Q19. Will the patient be monitored for signs of bleeding?

☐ Yes ☐ No

Q20. Is the patient a female of child bearing age?

☐ Yes ☐ No

Q21. Has pregnancy been ruled out as documented by a negative pregnancy test?

☐ Yes ☐ No

Q22. Is the requested drug a non-preferred idiopathic pulmonary fibrosis (IPF) agent?

☐ Yes ☐ No

Q23. Does the patient have history of therapeutic failure, contraindication or intolerance to the preferred idiopathic pulmonary fibrosis (IPF) agents approved or medically accepted for the beneficiary's indication?

☐ Yes ☐ No

Q24. Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred idiopathic pulmonary fibrosis (IPF) agent?

☐ Yes ☐ No

Q25. Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug or counseling of the beneficiary of the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

Q26. Since starting therapy with the requested drug, has the patient had repeat liver function tests (alanine aminotransferase [ALT], aspartate aminotransferase [AST], bilirubin) as described in the initial prior authorization guidelines?

☐ Yes ☐ No

Q27. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q28. Is the requested drug prescribed by or in consultation with a pulmonologist?

☐ Yes ☐ No

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Q29. Does the patient have end-stage renal disease requiring dialysis?

☐ Yes ☐ No

Q30. Does the patient have any of the following: A) Severe renal impairment or end-stage renal disease, B) Alanine aminotransferase (ALT), aspartate aminotransferase (AST) or bilirubin greater than 1.5 times the upper limit of normal, C) Active bleeding, D) A recent history of myocardial infarction or stroke, E) Gastrointestinal perforation, F) Severe diarrhea, nausea, or vomiting that persists despite symptomatic treatment.?

☐ Yes ☐ No

Q31. Additional Information:

Prescriber Signature

Date

Updated for 2020