Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Immunomodulators - Atopic Dermatitis

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. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?

☐ Yes ☐ No

Q2. Is the request for Eucrisa?

☐ Yes ☐ No

Q3. Does the patient have a documented history of therapeutic failure of, a contraindication to, or intolerance of a topical calcineurin inhibitor?

☐ Yes ☐ No

Q4. Is the patient's use of Eucrisa age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature?

☐ Yes ☐ No

Q5. Is the request for a non-preferred topical calcineurin inhibitor for a patient with a documented history of therapeutic failure of, a contraindication to, or intolerance of the preferred topical calcineurin inhibitors?

☐ Yes ☐ No

Q6. Additional Information:

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Patient Name:	Prescriber Name:

Prescriber Signature Date

Updated for 2020