



**HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

**Intranasal Rhinitis 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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

<p>Q1. Is this a request for triamcinolone nasal spray?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q2. Is the patient 4 years of age or older?</p> <p>[Note: Prior Authorization is not required for triamcinolone nasal spray for patients less than 4 years of age.]</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q3. Is this a request for an intranasal rhinitis drug (i.e., intranasal antihistamine or intranasal steroid) when there is a record of a recent paid claim for another intranasal rhinitis drug with the same mechanism of action (i.e., potential therapeutic duplication)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q4. Is the patient being titrated to or tapered from another intranasal rhinitis drug containing a drug with the same mechanism of action?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q5. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q6. Is this a request for a preferred intranasal rhinitis drug?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q7. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of a preferred intranasal</p>

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rhinitis drug with the same mechanism of action?

Yes

No

Q8. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated for 2020*