



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Iron Chelating 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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, etc.

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 a request for initiation of therapy with the requested drug? [If no, skip to question 10.]

Yes No

Q2. Is the requested drug being used for a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

Yes No

Q3. Is the patient age-appropriate for the requested drug according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

Yes No

Q4. Are the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

Yes No

Q5. Is the requested drug prescribed by or in consultation with a specialist (i.e. hematologist)?

Yes No

Q6. Does the patient have a history of a contraindication to the requested drug?

Yes No

Q7. Has baseline lab testing been done as recommended in the Food and Drug Administration (FDA)-approved package labeling? Note: Please attach documentation.



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Patient Name: Prescriber Name:

Q8. Is this a request for a non-preferred iron chelating agent?
Q9. Does the patient have documented therapeutic failure with or contraindication or intolerance to the preferred iron chelating agents approved or medically acceptable for the diagnosis?
Q10. Has the patient demonstrated tolerability and a positive clinical response to the requested drug?
Q11. Is the requested drug prescribed by or in consultation with a specialist (i.e. hematologist)?
Q12. Are the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?
Q13. Has the patient received recent lab monitoring as recommended in the Food and Drug Administration (FDA)-approved package labeling?
Q14. Is continuing treatment with the requested drug indicated based on recent lab results as recommended in the Food and Drug Administration (FDA)-approved package labeling?
Q15. Additional Information:

Prescriber Signature

Date

Updated for 2020