



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Macular Degeneration 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 the requested medication being used to treat a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA) approved package labeling, or a medically accepted indication?

Yes No

Q2. Is the requested medication prescribed by a retinal specialist?

Yes No

Q3. Is the prescribed dose and frequency of the requested medication consistent with the FDA-approved package labeling, nationally recognized compendia, or is medically accepted?

Yes No

Q4. Is the patient currently receiving treatment with the requested medication?

Yes No

Q5. Is there documentation of previous date(s) of administration of the requested medication?

Yes No

Q6. Does the patient have documentation of tolerability and a positive clinical response with the requested medication based on the prescriber's assessment?

Yes No

Q7. Does the patient have a documented history of therapeutic failure, intolerance, or contraindication to intravitreal bevacizumab?



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Patient Name:	Prescriber Name:
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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the patient unable to use intravitreal bevacizumab because of clinical reasons as documented by the prescriber (e.g., the patient has neovascular (wet) age-related macular degeneration)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the requested medication a non-preferred macular degeneration agent?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Does the patient have a documented history of therapeutic failure, intolerance, or contraindication to the preferred macular degenerative agents approved or medically accepted for the patient's diagnosis?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Additional Information:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

Updated for 2020