



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Oncology Agents, Oral

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, Strength, Refills, Specialty Pharmacy.

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 request for a renewal of prior authorization for an Oncology Agent, Oral that was previously approved? [Note: See the Preferred Drug List (PDL) for the list of preferred and non-preferred Oncology Agents, Oral at: https://papdl.com/preferred-drug-list]

Yes checkbox

No checkbox

Q2. Is there documentation of tolerability and a positive clinical response to the therapy?

Yes checkbox

No checkbox

Q3. Is the patient prescribed a dose that is consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q4. Is the requested Oncology Agent, Oral prescribed by or in consultation with an oncologist or hematologist?

Yes checkbox

No checkbox

Q5. Is the patient prescribed the Oncology Agent, Oral for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes checkbox

No checkbox

Q6. Is the patient prescribed a dose that is consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q7. Is the requested Oncology Agent, Oral prescribed by or in consultation with an oncologist or hematologist?

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Patient Name: Prescriber Name:

Yes No

Q8. Is the request for a non-preferred Oncology Agent, Oral?
[Note: See the Preferred Drug List (PDL) for the list of non-preferred Oncology Agents, Oral at: https://papdl.com/preferred-drug-list]

Yes No

Q9. Does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred Oncology Agents, Oral approved or medically accepted for the beneficiary's diagnosis?
[Note: See the Preferred Drug List (PDL) for the list of preferred and non-preferred Oncology Agents, Oral at: https://papdl.com/preferred-drug-list]

Yes No

Q10. Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred Oncology Agent, Oral?

Yes No

Q11. Additional Information:

Yes No

Prescriber Signature

Date

Updated for 2020