Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Potassium Removing 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: ☐ 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. Is the requested drug being prescribed by or in consultation with a cardiologist or nephrologist?

☐ Yes ☐ No

Q2. Is the requested drug being prescribed at a dose that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q4. Does the patient have documentation of recent serum potassium levels demonstrating a positive clinical response to therapy?

☐ Yes ☐ No

Q5. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q6. Is the requested drug age-appropriate according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q7. Does the patient have documentation of recent serum potassium levels consistent with a diagnosis of hyperkalemia?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Does the patient have documented failure of ALL of the following: A) a low potassium diet, B) a loop or thiazide diuretic (if clinically appropriate), C) discontinuation or dose reduction to the minimum effective dose of medications known to cause hyperkalemia? ☐ Yes ☐ No	
Q9. Is this a request for a preferred potassium removing agent? ☐ Yes ☐ No	
Q10. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred potassium removing agents? ☐ Yes ☐ No	
Q11. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2020