



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Proton Pump Inhibitors

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 this a request for a patient less than six (6) years of age when a proton pump inhibitor (PPI) has been prescribed for a total of four (4) months or more in the previous 180 day period?

Yes No

Q2. Does the patient have a chronic primary disease, such as cystic fibrosis, cerebral palsy, Down's Syndrome/mental retardation, or repaired esophageal atresia?

Yes No

Q3. Does the patient have documentation of a comprehensive evaluation and appropriate diagnostic testing confirming a diagnosis that requires chronic therapy?

Yes No

Q4. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

Yes No

Q5. Is this a request for an over-the-counter (OTC) proton pump inhibitor (PPI) for a patient with dual eligibility?

Yes No

Q6. Is the patient being prescribed the over-the-counter (OTC) proton pump inhibitor (PPI) as part of a Medicare Part D plan utilization management program, including a step-therapy or prior authorization program?

Yes No

Q7. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the proton pump inhibitors (PPIs) on the patient's Medicare Part D plan formulary?



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Patient Name: Prescriber Name:

Form containing questions Q8 through Q13 regarding PPI requests, including checkboxes for Yes/No and a section for additional information.

Prescriber Signature

Date

Updated for 2020