



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Pulmozyme

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, PA PROMISe ID, 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 requested drug being prescribed by or in consultation with a pulmonologist?

Yes No

Q2. Does the patient have a diagnosis of cystic fibrosis? (Please attach documentation of diagnosis)?

Yes No

Q3. Is the requested drug being prescribed in conjunction with standard therapies (such as disease-modifying [potentiator] drug, oral, inhaled and/or parenteral antibiotics, bronchodilators, pancreatic enzyme supplements, vitamins, oral or inhaled corticosteroids, inhaled hypertonic saline, analgesics, and chest physiotherapy) for cystic fibrosis?

Yes No

Q4. Will the requested drug be administered using a recommended jet nebulizer/compressor system or eRapid Nebulizer System?

Yes No

Q5. Is the requested drug being prescribed at a dose of 2.5 mg once daily?

Yes No

Q6. Is the requested drug being prescribed at a dose of 2.5 mg twice daily?

Yes No

Q7. Has documentation of an adequate trial of once daily dosing consisting of at least a 2 week trial been submitted? [Please attach documentation of previous trial.]

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party.



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Patient Name:	Prescriber Name:
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<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q8. Additional Information:

Prescriber Signature

Date

Updated for 2020