



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Strensiq

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.

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 continuation of therapy?

Yes checkbox

No checkbox

Q2. Does the patient have a diagnosis of perinatal/infantile-onset or juvenile-onset hypophosphatasia?

Yes checkbox

No checkbox

Q3. Are applicable labs and/or tests provided supporting the diagnosis?

Labs/tests include: X-rays results showing fractures, skeletal abnormalities, premature loss of deciduous teeth, bone loss or respiratory problems, labs showing low blood levels of alkaline phosphatase activity, elevated levels of phosphoethanolamine and pyridoxal 5'-phosphate and mutations in the gene encoding tissue nonspecific alkaline phosphatase (TNSALP).

Yes checkbox

No checkbox

Q4. Is the medication prescribed by (or in consultation with) an endocrinologist or a prescriber specializing in inherited metabolic disorders?

Yes checkbox

No checkbox

Q5. Has the patient been appropriately evaluated with confirmation that the patient does not have a treatable form of rickets, current exposure to a bisphosphonate, hypocalcemia, hypophosphatemia or a serum 25-Hydroxyvitamin D level of less than 20 ng/mL?

Yes checkbox

No checkbox

Q6. Is the requested dose within the Food and Drug Administration (FDA) labeled dosing guidelines (patient's weight must be provided)?



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Patient Name: Prescriber Name:

Yes No

Q7. Has documentation of clinical benefit been provided, as shown by improvement in any of the following: radiographic findings, respiratory assessments, pulmonary function testing, growth parameters, mobility, pain assessments?

Yes No

Q8. Has documentation of ophthalmic and renal monitoring (concern for ophthalmic or renal ectopic calcifications) been provided?

Yes No

Q9. Is the requested dose within the Food and Drug Administration (FDA) labeled dosing guidelines (patient's weight must be provided)?

Yes No

Q10. Additional Information:

Prescriber Signature

Date

Updated for 2020