



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Urea Cycle Disorder 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.

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, etc.

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 with the requested drug (i.e., this medication was previously approved by a HPP prior authorization)?

Yes No

Q2. 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

Q3. Is there chart documentation supporting the diagnosis (e.g., ammonia levels, genetic testing, enzyme assays, plasma amino acid/urine orotic acid analyses, progress notes)?

Yes No

Q4. Is the requested drug prescribed a dose and duration of therapy that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q5. If the requested drug a non-preferred urea cycle disorder agent?

Yes No

Q6. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to the preferred urea cycle disorder agent?

Yes No



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Patient Name: Prescriber Name:

Q7. Is there documentation from the prescribing provider that the beneficiary had a positive clinical response to therapy?
Yes No

Q8. Is the requested drug prescribed by or in consultation with a physician who specializes in treating metabolic disorders?
Yes No

Q9. Is the requested drug prescribed a dose and duration of therapy that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?
Yes No

Q10. Additional Information:

Prescriber Signature

Date

Updated for 2020