Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Acne Agents - Oral

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. Does the patient have a diagnosis that is indicated in the United States (US) Food and Drug Administration (FDA) approved package labeling OR a medically-accepted indication?

☐ Yes ☐ No

Q2. Is the patient of an appropriate age for the requested drug according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Is the patient prescribed a dose and duration of therapy that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the requested oral acne agent prescribed by or in consultation with a dermatologist?

☐ Yes ☐ No

Q5. Is the requested drug being prescribed for acne?

☐ Yes ☐ No

Q6. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of ALL of the following: A) an oral antibiotic recommended for the treatment of acne, B) a topical antibiotic recommended for the treatment of acne, C) a topical tretinoin?

☐ Yes ☐ No

Q7. Is this a request for a preferred oral acne agent (e.g., Amnesteem, Claravis, isotretinoin, Myorisan, Zenatane)?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred oral acne agents (e.g., Amnesteem, Claravis, isotretinoin, Myorisan, Zenatane)?	
☐ Yes	☐ No
Q9. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2020