



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)

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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP | Specialty Pharmacy (if applicable): | | |
| Drug Name: | Strength: | | |
| Quantity: | Refills: | | |
| Directions: | | | |
| Diagnosis Code: | Diagnosis: | | |
| <i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i> | | | |

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

| |
|---|
| <p>Q1. Is this a request for oral or nasal ketorolac (Toradol)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>Q2. Is the requested drug age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>Q3. Is the patient prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>Q4. Is the patient taking concomitant aspirin or any other nonsteroidal anti-inflammatory drugs (NSAIDs)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>Q5. Is this a request for a non-preferred nonsteroidal anti-inflammatory drug (NSAID)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>Q6. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred NSAIDs (excluding ketorolac) with the same route of administration?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>Q7. Is this a request for an NSAID when there is a record of a recent paid claim for another NSAID (i.e., potential therapeutic duplication)?</p> |

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Patient Name: Prescriber Name:

Yes No

Q8. Is the patient being transitioned to another drug in the same class with the intent of discontinuing one of the medications?

Yes No

Q9. Has the prescriber provided a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?

Yes No

Q10. Additional Information:

Prescriber Signature

Date

Updated for 2021