



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Colony Stimulating Factors

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, 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 prescribed for either of the following: A) an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling, or B) a medically accepted indication?

Yes No

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

Yes No

Q3. Is the requested drug prescribed by or in consultation with a hematologist or oncologist?

Yes No

Q4. Does the patient have a history of a contraindication to the prescribed drug?

Yes No

Q5. Is the requested drug prescribed for primary prophylaxis of chemotherapy-induced febrile neutropenia in a patient with non-myeloid malignancy?

Yes No

Q6. Will the patient be receiving a chemotherapy regimen with an expected incidence of febrile neutropenia greater than 20 percent as defined by the National Comprehensive Cancer Network (NCCN)?

Yes No

Q7. Does the patient have risk factors for developing febrile neutropenia as defined by the National Comprehensive Cancer Network (NCCN)?

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Form with fields for Patient Name, Prescriber Name, and questions Q8-Q11 regarding drug Neulasta, medication timing, preferred drug list, and history of failure. Includes checkboxes for Yes/No and a field for Additional Information (Q12).

Prescriber Signature

Date

Updated for 2022