



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Enzyme Replacements - Gaucher Disease

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 this a request for initial therapy with the requested agent?

[If no, skip to question 12.]

Yes checkbox

No checkbox

Q2. Is the requested drug being used for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA) - approved package labeling or a medically accepted indication?

Yes checkbox

No checkbox

Q3. Is the patient age-appropriate for the requested drug according to Food and Drug Administration (FDA) - approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q4. Is the prescribed dose consistent with Food and Drug Administration (FDA) - approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q5. Does the patient have a history of contraindication to the requested drug?

Yes checkbox

No checkbox

Q6. Is the requested medication prescribed by or in consultation with a specialist in the treatment of Gaucher disease?

Yes checkbox

No checkbox

Q7. Is this request for a non-preferred agent?

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party.



**HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

**Enzyme Replacements - Gaucher Disease**

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:
---------------	------------------

<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Has the patient tried and failed or had a contraindication or intolerance to the preferred agents approved or medically accepted for the patient's indication?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the patient have a diagnosis of Gaucher disease?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Does the patient have one of the following: A) Enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) activity, B) Deoxyribonucleic acid (DNA) testing confirming the diagnosis? Note: Please attach documentation of the lab test.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Does the patient have a diagnosis of one of the following: A) Anemia, B) Bone disease, C) Hepatomegaly, D) Interstitial lung disease, E) Splenomegaly, F) Thrombocytopenia? Note: Please attach documentation.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Has the plan previously approved the requested drug for this patient (previous authorization is on file under this plan)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Is the prescribed dose consistent with Food and Drug Administration (FDA) – approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Is the requested medication prescribed by or in consultation with a specialist in the treatment of Gaucher disease?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Has the disease severity improved since initiating treatment with the requested drug? Note: Please provide documentation of disease improvement.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



**HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

**Enzyme Replacements - Gaucher Disease**

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:
---------------	------------------

*Updated for 2022*