



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Intra-Articular Hyaluronates

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 request for renewal of therapy?

Yes checkbox

No checkbox

Q2. Is the requested drug being used for 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. Has the patient had a documented history of therapeutic failure, contraindication or intolerance to all of the following: A) Non-pharmacologic treatments, B) Acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs) and C) Intra-articular glucocorticoid injection?

Yes checkbox

No checkbox

Q4. Does the member have a contraindication to the requested drug?

Yes checkbox

No checkbox

Q5. Is this a request for a non-preferred product?

Yes checkbox

No checkbox

Q6. Has the member had a documented history or therapeutic failure, contraindication or intolerance to the preferred intra-articular hyaluronate products?

Yes checkbox

No checkbox

Q7. Has the member demonstrated improvement in pain or joint function following the first treatment? Note: Please attach documentation of this improvement.



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Patient Name:	Prescriber Name:
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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Has the member received an intra-articular hyaluronate injection in the same knee within the past 6 months?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the member have a contraindication to the requested drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Additional Information:	

Prescriber Signature

Date

Updated for 2022