Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Leukotriene Modifiers

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. Is this a request for montelukast granules?
☐ Yes ☐ No

Q2. Is the patient less than 2 years of age?
[Note: Prior Authorization is not required for patients less than 2 years of age.]
☐ Yes ☐ No

Q3. Is this a request for a preferred leukotriene modifier (e.g., montelukast tablet, montelukast chewable tablet)?
☐ Yes ☐ No

Q4. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred leukotriene modifier (e.g., montelukast tablet, montelukast chewable tablet)?
☐ Yes ☐ No

Q5. Is this a request for a leukotriene modifier when there is a record of a recent paid claim for another leukotriene modifier (i.e., potential therapeutic duplication)?
☐ Yes ☐ No

Q6. Is the patient being titrated to, or tapered from, a drug in the same class?
☐ Yes ☐ No

Q7. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2022