Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Macular Degeneration Agents

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 the requested medication being used to treat a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA) approved package labeling, or a medically accepted indication?

☐ Yes ☐ No

Q2. Is the requested medication prescribed by a retinal specialist?

☐ Yes ☐ No

Q3. Is the prescribed dose and frequency of the requested medication consistent with the FDA-approved package labeling, nationally recognized compendia, or is medically accepted?

☐ Yes ☐ No

Q4. Is the patient currently receiving treatment with the requested medication?

☐ Yes ☐ No

Q5. Is there documentation of previous date(s) of administration of the requested medication?

☐ Yes ☐ No

Q6. Does the patient have documentation of tolerability and a positive clinical response with the requested medication based on the prescriber's assessment?

☐ Yes ☐ No

Q7. Does the patient have a documented history of therapeutic failure, intolerance, or contraindication to intravitreal bevacizumab?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Is the patient unable to use intravitreal bevacizumab because of clinical reasons as documented by the prescriber (e.g., the patient has neovascular (wet) age-related macular degeneration)?	
☐ Yes	☐ No
Q9. Is the requested medication a non-preferred macular degeneration agent?	
☐ Yes	☐ No
Q10. Does the patient haven a documented history of therapeutic failure, intolerance, or contraindication to the preferred macular degenerative agents approved or medically accepted for the patient's diagnosis?	
☐ Yes	☐ No
Q11. Additional Information:	
☐ Yes	☐ No

Prescriber Signature

Date

Updated for 2022