



**HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

**Platelet Aggregation Inhibitors**

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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

<p>Q1. Is this a request for Zontivity (vorapaxar)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q2. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred platelet aggregation inhibitors (e.g., Aggrenox, Brilinta, clopidogrel, dipyridamole tablet, prasugrel)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q3. Is Zontivity (vorapaxar) being prescribed for a condition that is United States (US) Food and Drug Administration (FDA) approved or a medically-accepted indication?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q4. Will the patient be taking Zontivity (vorapaxar) in addition to aspirin and/or clopidogrel?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q5. Is Zontivity (vorapaxar) being prescribed by or in consultation with a cardiologist or other vascular specialist?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q6. Does the patient have any contraindications to Zontivity (vorapaxar)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q7. Will the patient be taking any of the following concomitantly with Zontivity:</p> <p>A) anticoagulants, B) chronic nonsteroidal anti-inflammatory drugs (NSAIDs), C) selective serotonin reuptake inhibitors (SSRIs),</p>

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Patient Name: Prescriber Name:

Q7. D) serotonin-norepinephrine reuptake inhibitors (SNRIs)?
Q8. Have any potential drug interactions been addressed by the prescriber?
Q9. Does the patient have severe hepatic impairment?
Q10. Additional Information:

Prescriber Signature

Date

Updated for 2022