



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Potassium Removing 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.

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 the requested drug being prescribed by or in consultation with a cardiologist or nephrologist?

Yes No

Q2. Is the requested drug being prescribed at a dose that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q3. Is this a request for a renewal of authorization?

Yes No

Q4. Does the patient have documentation of recent serum potassium levels demonstrating a positive clinical response to therapy?

Yes No

Q5. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?

Yes No

Q6. Is the requested drug age-appropriate according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q7. Does the patient have documentation of recent serum potassium levels consistent with a diagnosis of hyperkalemia?

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Patient Name: Prescriber Name:

Yes No

Q8. Does the patient have documented failure of ALL of the following:

- A) a low potassium diet,
B) a loop or thiazide diuretic (if clinically appropriate),
C) discontinuation or dose reduction to the minimum effective dose of medications known to cause hyperkalemia?

Yes No

Q9. Is this a request for a preferred potassium removing agent?

Yes No

Q10. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred potassium removing agents?

Yes No

Q11. Additional Information:

Prescriber Signature

Date

Updated for 2022