Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Sickle Cell Anemia 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. Has the patient previously received prior authorization approval for the requested drug?

☐ Yes ☐ No

Q2. Is the requested medication being prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q3. Is the patient age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the prescribed dose for the requested medication consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Is the requested medication being prescribed by or in consultation with a hematologist/oncologist or sickle cell disease specialist?

☐ Yes ☐ No

Q6. Have all potential drug interactions been addressed (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q7. Does the patient have a history of therapeutic failure, contraindication, or intolerance to maximum tolerated doses of hydroxyurea for at least 6 months?

☐ Yes ☐ No

Q8. Is there documentation that the patient tolerated and had a positive clinical response to the medication?

☐ Yes ☐ No

Q9. Is the prescribed dose for the requested medication consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q10. Is the requested medication being prescribed by or in consultation with a hematologist/oncologist or sickle cell disease specialist?

☐ Yes ☐ No

Q11. Have all potential drug interactions been addressed (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

Q12. Additional Information:

Prescriber Signature

Date

Updated for 2022