



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Thalidomide and Derivatives

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 medication prescribed by or in consultation with an appropriate specialist (i.e., hematologist/oncologist)?

Yes No

Q2. Is the prescribed dose and duration of therapy consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q3. Is this a request for continuation of therapy?

Yes No

Q4. Is the requested medication for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes No

Q5. Is the request for a non-preferred agent?

Yes No

Q6. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to the preferred Thalidomide and Derivatives approved or medically accepted for the beneficiary's diagnosis?

[Note: documentation must be attached.]

Yes No

Q7. Is documentation of the therapeutic failure, contraindication, or intolerance to the preferred Thalidomide and

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Patient Name:	Prescriber Name:
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Derivatives attached to this request? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred Thalidomide and Derivative? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q9. Has the patient been tolerant to the requested medication and had a positive clinical response to the medication? [Note: documentation must be attached.] <input type="checkbox"/> Yes <input type="checkbox"/> No
Q10. Is documentation of tolerability and positive clinical response attached to this request? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q11. Additional Information:

Prescriber Signature

Date

Updated for 2022