



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Anticoagulants

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 patient being prescribed a dose and duration of therapy that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q2. Does the patient have a history of a contraindication to the requested drug?

Yes No

Q3. Is this a request for an oral or injectable anticoagulant when there is a record of a recently paid claim for another anticoagulant with the same route of administration (i.e., potential therapeutic duplication)?

Yes No

Q4. Is the patient being titrated to or tapered from another anticoagulant with the same route of administration as the requested drug?

Yes No

Q5. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

Yes No

Q6. Is this a request for a preferred anticoagulant drug?

Yes No

Q7. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred anticoagulant drugs approved or medically accepted for the patient's diagnosis or indication?

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party.



**HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

**Anticoagulants**

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:
---------------	------------------

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

Q8. Additional Information:
-----------------------------

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated for 2022*