



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Beta Blockers

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, etc.

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 this a request for Hemangeol (propranolol hydrochloride oral solution)?

Yes No

Q2. Is the requested drug being prescribed by or in consultation with an appropriate specialist (e.g., pediatric dermatologist, hematologist, or oncologist)?

Yes No

Q3. Is the patient 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

Q4. Is this a request for a renewal of authorization?

Yes No

Q5. Does the patient have documentation of improvement in disease severity since initiating treatment with the requested drug?

Yes No

Q6. Is the requested drug prescribed for an indication that is included in the Food and Drug Administration (FDA) approved package labeling?

Yes No

Q7. Is the requested drug age-appropriate for the patient according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

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Patient Name: Prescriber Name:

Yes No

Q8. Is this a request for a beta blocker drug when there is a record of a recent paid claim for another beta blocker (i.e., potential therapeutic duplication)?
Yes No

Q9. Is the patient being titrated to, or tapered from, a drug in the same class?
Yes No

Q10. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?
Yes No

Q11. Is this a request for a preferred beta blocker drug (e.g., acebutolol, atenolol, atenolol/chlorthalidone, bisoprolol, bisoprolol/hydrochlorothiazide, carvedilol, Hemangeol, labetalol tablet, metoprolol succinate extended-release, metoprolol tartrate tablet, pindolol, propranolol tablet, propranolol oral solution, propranolol extended-release, propranolol/hydrochlorothiazide, sotalol, sotalol AF)?
Yes No

Q12. Does the patient have a documented history of therapeutic failure, intolerance of, or contraindication to the preferred beta blocker drugs approved or medically accepted for the patient's diagnosis (e.g., acebutolol, atenolol, atenolol/chlorthalidone, bisoprolol, bisoprolol/hydrochlorothiazide, carvedilol, Hemangeol, labetalol tablet, metoprolol succinate extended-release, metoprolol tartrate tablet, pindolol, propranolol tablet, propranolol oral solution, propranolol extended-release, propranolol/hydrochlorothiazide, sotalol, sotalol AF)?
Yes No

Q13. Additional Information:

Prescriber Signature

Date

Updated for 2022