Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Strensiq

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. Is this a request for continuation of therapy?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of perinatal/infantile-onset or juvenile-onset hypophosphatasia?

☐ Yes ☐ No

Q3. Are applicable labs and/or tests provided supporting the diagnosis?
Labs/tests include: X-rays results showing fractures, skeletal abnormalities, premature loss of deciduous teeth, bone loss or respiratory problems, labs showing low blood levels of alkaline phosphatase activity, elevated levels of phosphoethanolamine and pyridoxal 5'-phosphate and mutations in the gene encoding tissue nonspecific alkaline phosphatase (TNSALP).

☐ Yes ☐ No

Q4. Is the medication prescribed by (or in consultation with) an endocrinologist or a prescriber specializing in inherited metabolic disorders?

☐ Yes ☐ No

Q5. Has the patient been appropriately evaluated with confirmation that the patient does not have a treatable form of rickets, current exposure to a bisphosphonate, hypocalcemia, hypophosphatemia or a serum 25-Hydroxyvitamin D level of less than 20 ng/mL?

☐ Yes ☐ No

Q6. Is the requested dose within the Food and Drug Administration (FDA) labeled dosing guidelines (patient's weight must be provided)?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q7. Has documentation of clinical benefit been provided, as shown by improvement in any of the following: radiographic findings, respiratory assessments, pulmonary function testing, growth parameters, mobility, pain assessments?	
☐ Yes	☐ No
Q8. Has documentation of ophthalmic and renal monitoring (concern for ophthalmic or renal ectopic calcifications) been provided?	
☐ Yes	☐ No
Q9. Is the requested dose within the Food and Drug Administration (FDA) labeled dosing guidelines (patient's weight must be provided)?	
☐ Yes	☐ No
Q10. Additional Information:	

Prescriber Signature

Date

Updated for 2022