



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Idiopathic Pulmonary Fibrosis 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.

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 request for renewal of therapy (i.e., The requested drug has been previously approved on prior authorization)?

Yes No

Q2. Is the requested drug being prescribed 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

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

Yes No

Q4. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

Yes No

Q5. Is the requested drug prescribed by or in consultation with an appropriate specialist (e.g., pulmonologist, rheumatologist, etc.)?

Yes No

Q6. Have all potential drug interactions been addressed by the prescriber (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

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.



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Patient Name:	Prescriber Name:
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<p>Q7. Does the patient have a history of a contraindication to the prescribed medication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Does the patient currently smoke?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q9. Is there documentation of being advised by the prescriber to stop smoking?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q10. Is the requested drug a non-preferred idiopathic pulmonary fibrosis (IPF) agent?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q11. Does the patient have history of therapeutic failure, contraindication or intolerance to the preferred idiopathic pulmonary fibrosis (IPF) agents approved or medically accepted for the patient's indication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q12. Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred idiopathic pulmonary fibrosis (IPF) agent?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q13. Is the patient benefitting from the requested drug, based on the prescriber's assessment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q14. Have all potential drug interactions been addressed by the prescriber (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)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q15. Is the requested drug prescribed by or in consultation with an appropriate specialist (e.g., pulmonologist, rheumatologist, etc.)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q16. Does the patient have a history of a contraindication to the prescribed drug?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q17. Additional Information:</p>



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Patient Name:	Prescriber Name:
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Prescriber Signature

Date

Updated for 2022