Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Immunomodulators - Atopic Dermatitis

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 the request for a topical JAK inhibitor (e.g. Opzelura, topical ruxolitnib cream)?

☐ Yes ☐ No

Q2. Is the prescribed topical JAK inhibitor for the treatment of a diagnosis that is indicated in the FDA-approved package labeling OR medically accepted indication?

☐ Yes ☐ No

Q3. Is the patient being the prescribed topical JAK inhibitor of the appropriate age per FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Does the patient being prescribed the topical JAK inhibitor have a history of therapeutic failure of or a contraindication or an intolerance to a topical corticosteroid approved or medically accepted for the treatment of the patient's diagnosis?

☐ Yes ☐ No

Q5. Does the patient being prescribed the topical JAK inhibitor have a history of therapeutic failure of or a contraindication or an intolerance to a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis?

☐ Yes ☐ No

Q6. Is the request for a topical PDE4 inhibitor (e.g. Eucrisa, topical crisaborole) 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 ?

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Immunomodulators - Atopic Dermatitis

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:

☐ Yes	☐ No
Q7. Is the patient being prescribed the topical PDE4 inhibitor (e.g. Eucrisa, topical crisaborole) of appropriate age according to FDA-approved package labeling, nationally recognized compendia, or peer reviewed literature?	
☐ Yes	☐ No
Q8. Does the patient being prescribed the topical PDE4 inhibitor, have a documented history of therapeutic failure of, a contraindication to, or intolerance of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis?	
☐ Yes	☐ No
Q9. Is the request for a non-preferred topical calcineurin inhibitor for a patient with a documented history of therapeutic failure of, a contraindication to, or intolerance of the preferred topical calcineurin inhibitors (i.e. brand name Elidel and brand name Protopic)?	
☐ Yes	☐ No
Q10. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2022