



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

Glucocorticoids - Inhaled

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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

<p>Q1. Is this a request for an inhaled glucocorticoid agent when there is a recent paid claim for another agent that contains an inhaled glucocorticoid (i.e., potential therapeutic duplication)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is the patient being titrated to or tapered from another agent that contains an inhaled glucocorticoid?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the patient being titrated to or tapered from another inhaled long-acting anticholinergic?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is the patient being titrated to or tapered from another inhaled long acting beta agonist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is this a request for a non-preferred single-ingredient inhaled glucocorticoid agent?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred single-ingredient inhaled glucocorticoid agents?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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Patient Name:	Prescriber Name:
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Q8. Is this a request for a non-preferred inhaled glucocorticoid combination agent?

Yes No

Q9. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred inhaled glucocorticoid combination agents?

Yes No

Q10. Additional Information:

Prescriber Signature

Date

Updated for 2022