



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

GI Motility Agents - Chronic

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 the patient prescribed a dose that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q2. Does the patient have a contraindication to the requested medication?

Yes No

Q3. Is this a request for a drug indicated for the treatment of a diagnosis involving diarrhea?

Yes No

Q4. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

Yes No

Q5. Is this a request for a renewal of authorization? [If no, then skip to question 7.]

Yes No

Q6. Does the patient have documentation of tolerability and a positive clinical response to the medication?

Yes No

Q7. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?

Yes No



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Patient Name: Prescriber Name:

Q8. Is the requested drug age-appropriate according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?
Q9. Is the requested drug indicated for treatment of a diagnosis involving constipation [If no, skip to question 11]?
Q10. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of TWO of the following: A) laxatives, B) fiber supplementation, C) osmotic agents, D) bulk forming agents, E) glycerin or bisacodyl suppositories?
Q11. For an agent indicated for the treatment of a diagnosis involving diarrhea, does the patient have a documented therapeutic failure of a low fermentable oligosaccharides, disaccharides, and monosaccharides and polyols (FODMAP) diet? Yes
Q12. Is this a request for a preferred chronic gastrointestinal (GI) motility agent?
Q13. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred chronic gastrointestinal (GI) motility agents approved or medically accepted for the patient's diagnosis?
Q14. Requested Duration:
Q15. Additional Information:

Prescriber Signature

Date

Updated for 2022