



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Erythropoiesis Stimulating Agents (ESAs)

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.

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 prescribed ESA being used for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

Yes No

Q2. Is the prescribed ESA by or in consultation with an appropriate specialist (i.e., gastroenterologist, hematologist/oncologist, infectious disease specialist, nephrologist, surgeon, etc)?

Yes No

Q3. Does the patient have a contraindication to the prescribed ESA?

Yes No

Q4. Is the prescribed dose and duration of therapy consistent with FDA- approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q5. Has the patient been evaluated and treated for other causes of anemia (e.g. iron deficiency, hemolysis, vitamin B12 deficiency, folate deficiency, etc)?

Yes No

Q6. Does the patient have a serum ferritin >= 100 mcg/L and serum transferrin saturation >= 20% OR receiving supplemental iron therapy?

Yes No

Q7. Does the patient have the diagnosis of anemia associated with chronic kidney disease?



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Erythropoiesis Stimulating Agents (ESAs)

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:

Form containing 18 questions (Q8-Q18) with Yes/No checkboxes regarding drug continuation, hemoglobin levels, and treatment outcomes.

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.



HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Erythropoiesis Stimulating Agents (ESAs)

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:
---------------	------------------

<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Is this a request for a continuation of therapy with the requested drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Has the patient experienced a documented increase in hemoglobin or is prescribed an increased dose of the requested ESA consistent with FDA approved package labeling or peer reviewed medical literature?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q21. Does the patient meet all of the following: 1) Has Hemoglobin less than or equal to 12 g/dL, 2) Has a serum erythropoietin level less than or equal to 500 mUnits/mL, 3) is receiving a dose of zidovudine less than or equal to 4200 mg/week 4) Has serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20% OR is receiving supplemental iron therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q22. Will the requested drug be used to reduce allogenic blood transfusion in a surgical patient?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q23. Does the patient meet all of the following: 1) Pretreatment Hemoglobin greater than 10 g/dL but less than or equal to 13 g/d; , 2) Is undergoing elective, non cardiac, non vascular surgery?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q24. Is the request for a non-preferred product?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q25. Is this a request for continuation of therapy with the requested drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q26. Has the patient experienced a documented increase in hemoglobin or is prescribed an increased dose of the requested ESA consistent with FDA approved package labeling or peer reviewed medical literature?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q27. Does the patient meet the following: 1) Has serum ferritin greater than or equal to 100 mcg/L and serum transferrin saturation greater than or equal to 20% OR is receiving supplemental iron therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q28. Does the patient have a documented history of therapeutic failure, contraindication or intolerance of the preferred erythropoiesis stimulation proteins approved or medically accepted for the beneficiary's diagnosis?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



**HEALTH PARTNERS PLANS  
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

**Erythropoiesis Stimulating Agents (ESAs)**

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:
---------------	------------------

Q29. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated for 2022*