



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Acne Agents - Oral

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. Does the patient have a diagnosis that is indicated in the United States (US) Food and Drug Administration (FDA) approved package labeling OR a medically-accepted indication?

Yes No

Q2. Is the patient of an appropriate age for the requested drug according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q3. Is the patient prescribed a dose and duration of therapy that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

Q4. Is the requested oral acne agent prescribed by or in consultation with a dermatologist?

Yes No

Q5. Is the requested drug being prescribed for acne?

Yes No

Q6. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of ALL of the following: A) an oral antibiotic recommended for the treatment of acne, B) a topical antibiotic recommended for the treatment of acne, C) a topical tretinoin?

Yes No

Q7. Is this a request for a preferred oral acne agent (e.g., Amnesteem, Claravis, isotretinoin, Myorisan, Zenatane)?

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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Yes

No

Q8. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred oral acne agents (e.g., Amnesteem, Claravis, Myorisan, Zenatane)?

Yes

No

Q9. Additional Information:

Prescriber Signature

Date

Updated for 2022