Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Intra-Articular Hyaluronates

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 this request for renewal of therapy?

☐ Yes ☐ No

Q2. Is the requested drug being used for a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q3. Has the patient had a documented history of therapeutic failure, contraindication or intolerance to all of the following: A) Non-pharmacologic treatments, B) Acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs) and C) Intra-articular glucocorticoid injection?

☐ Yes ☐ No

Q4. Does the member have a contraindication to the requested drug?

☐ Yes ☐ No

Q5. Is this a request for a non-preferred product?

☐ Yes ☐ No

Q6. Has the member had a documented history or therapeutic failure, contraindication or intolerance to the preferred intra-articular hyaluronate products?

☐ Yes ☐ No

Q7. Has the member demonstrated improvement in pain or joint function following the first treatment? Note: Please attach documentation of this improvement.

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Has the member received an intra-articular hyaluronate injection in the same knee within the past 6 months?	
☐ Yes	☐ No
Q9. Does the member have a contraindication to the requested drug?	
☐ Yes	☐ No
Q10. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2023