Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Nonsteroidal Anti-Inflammatory Drugs (NSAIDS)

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 a request for oral or nasal ketorolac?

☐ Yes ☐ No

Q2. Is the requested drug age-appropriate according to 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 FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the patient taking aspirin or any other nonsteroidal anti-inflammatory drugs (NSAIDs) concurrently?

☐ Yes ☐ No

Q5. Is this a request for a non-preferred oral nonsteroidal anti-inflammatory drug (NSAID)?

☐ Yes ☐ No

Q6. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the oral preferred NSAIDs (excluding ketorolac) with the same route of administration?

☐ Yes ☐ No

Q7. Is this a request for non-preferred topical NSAID?

☐ Yes ☐ No

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Q8. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the topical preferred NSAIDs?

☐ Yes ☐ No

Q9. Is this a request for a non-preferred nasal ketorolac?

☐ Yes ☐ No

Q10. Does the patient have a clinical reason as documented by the prescriber why oral ketorolac cannot be used?

☐ Yes ☐ No

Q11. Is this a request for any other non-preferred non-oral nonsteroidal anti-inflammatory drug (NSAID)?

☐ Yes ☐ No

Q12. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to the preferred NSAIDs?

☐ Yes ☐ No

Q13. Does the patient have a clinical reason as documented by the prescriber why the routes of administration of the preferred NSAIDs cannot be used?

☐ Yes ☐ No

Q14. Is this a request for a non-preferred NSAID combination drug with more than one active ingredient (e.g., Duexis, Vimovo, etc.)?

☐ Yes ☐ No

Q15. Does the patient have a clinical reason as documented by the prescriber why the individual active ingredients cannot be used concurrently?

☐ Yes ☐ No

Q16. Is this a request for an NSAID when there is a record of a recent paid claim for another NSAID (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q17. Is the patient being transitioned to another drug in the same class with the intent of discontinuing one of the medications?

☐ Yes ☐ No

Q18. Has the prescriber provided a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q19. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023