



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Antipsoriatics - Topical

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 requested drug prescribed for the treatment of a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?

Yes No

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

Yes No

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

Yes No

Q4. For a topical AhR agonist (Vtama),

a. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to a 4-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis; -AND- b. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to an 8-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis

Yes No

Q5. For a topical PDE4 inhibitor (Zoryve).

a. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to a 4-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis -AND- b. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to an 8-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis

Yes No

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Patient Name:	Prescriber Name:
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Q6. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred topical antipsoriatic agents?

Yes

No

Q7. Additional Information:

Prescriber Signature

Date

Updated for 2023