Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Oncology 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.

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 the request for a renewal of prior authorization for an Oncology Agent, Oral that was previously approved? [Note: See the Preferred Drug List (PDL) for the list of preferred and non-preferred Oncology Agents, Oral at: https://papdl.com/preferred-drug-list]

☐ Yes ☐ No

Q2. Is there documentation of tolerability and a positive clinical response to the therapy?

☐ Yes ☐ No

Q3. Is the patient prescribed a dose 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 Oncology Agent, Oral prescribed by or in consultation with an oncologist or hematologist?

☐ Yes ☐ No

Q5. Is the patient prescribed the Oncology Agent, Oral for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q6. Is the patient prescribed a dose that is consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q7. Is the requested Oncology Agent, Oral prescribed by or in consultation with an oncologist or hematologist?

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Oncology 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.

Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Is the request for a non-preferred Oncology Agent, Oral? [Note: See the Preferred Drug List (PDL) for the list of non-preferred Oncology Agents, Oral at: https://papdl.com/preferred-drug-list]	
☐ Yes	☐ No
Q9. Does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred Oncology Agents, Oral approved or medically accepted for the beneficiary's diagnosis? [Note: See the Preferred Drug List (PDL) for the list of preferred and non-preferred Oncology Agents, Oral at: https://papdl.com/preferred-drug-list]	
☐ Yes	☐ No
Q10. Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred Oncology Agent, Oral?	
☐ Yes	☐ No
Q11. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2023