HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Angiotensin Modulators - Combinations

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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member 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 a preferred angiotensin modulator combination drug (e.g., amlodipine/benazepril, amlodipine/valsartan, amlodipine/valsartan/hydrochlorothiazide)?

☐ Yes ☐ No

Q2. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred angiotensin modulator combination drugs (e.g., amlodipine/benazepril, amlodipine/valsartan, amlodipine/valsartan/hydrochlorothiazide)?

☐ Yes ☐ No

Q3. Is this a request for an angiotensin modulator combination drug when there is a record of a recent paid claim for a calcium channel blocker, angiotensin-converting enzyme (ACE) inhibitor, angiotension receptor blocker (ARB), or another angiotension modulator combination (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q4. Is the patient being titrated to, or tapered from, a drug in the same class?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q5. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q6. Additional Information:

☐ Yes ☐ No

Prescriber Signature _____ Date _____

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