HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

ANTIFIBROTIC RESPIRATORY AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antifibrotic Respiratory Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Formulation (powder, tablet, etc.):
Dose/directions:		Quantity: / Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):
Is the medication being prescribed by or in consultation with a pulmonologist, rheumatologist, or other specialist?		☐Yes ☐No *Submit documentation of consultation, if applicable.*
Is the beneficiary currently being treated with the requested medication?		☐Yes ☐No *If yes, submit documentation.*
If applicable, has the dose of the requested medication been adjusted for the beneficiary's degree of liver impairment, concomitant medications, adverse effects, etc.?		☐Yes ☐No *Submit documentation.*
INITIAL requests		
For a non-preferred Antifibrotic Respiratory Agent, does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to the preferred Antifibrotic Respiratory Agents appropriate for the beneficiary's diagnosis or indication? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*		☐Yes ☐No *Submit documentation.*
Is the beneficiary a current smoker? If yes, did the prescriber advise the beneficiary to stop smoking?		☐Yes ☐No ☐Yes ☐No *Submit documentation.*
RENEWAL requests		
Has the beneficiary experienced a positive clinical response to the requested medication?		☐Yes ☐No *Submit documentation.*
Did the beneficiary experience any adverse reactions that require dose adjustment as described in the FDA-approved product labeling (e.g., liver enzyme elevations, GI reaction, photosensitivity reaction, rash)?		☐Yes ☐No *Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: