HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Iron Chelating Agents

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 initiation of therapy with the requested drug?
[If no, skip to question 10.]

☐ Yes ☐ No

Q2. Is the requested drug being used for a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q3. Is the patient age-appropriate for the requested drug according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Are the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Is the requested drug prescribed by or in consultation with a specialist (i.e. hematologist)?

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Member Name:	Prescriber Name:

☐ Yes ☐ No

Q6. Does the patient have a history of a contraindication to the requested drug?

☐ Yes ☐ No

Q7. Has baseline lab testing been done as recommended in the Food and Drug Administration (FDA)-approved package labeling? Note: Please attach documentation.

☐ Yes ☐ No

Q8. Is this a request for a non-preferred iron chelating agent?

☐ Yes ☐ No

Q9. Does the patient have documented therapeutic failure with or contraindication or intolerance to the preferred iron chelating agents approved or medically acceptable for the diagnosis? Note: Please attach documentation.

☐ Yes ☐ No

Q10. Has the patient demonstrated tolerability and a positive clinical response to the requested drug? Note: Please attach documentation.

☐ Yes ☐ No

Q11. Is the requested drug prescribed by or in consultation with a specialist (i.e. hematologist)?

☐ Yes ☐ No

Q12. Are the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q13. Has the patient received recent lab monitoring as recommended in the Food and Drug Administration (FDA)-approved package labeling? Note: Please attach results.

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q14. Is continuing treatment with the requested drug indicated based on recent lab results as recommended in the Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q15. Additional Information:

_____ _____

Prescriber Signature Date

v2025