HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Ophthalmics - Anti-Inflammatories

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. Does the patient have a documented history of therapeutic failure, intolerance, or contraindication to one of the preferred Ophthalmics, Anti-Inflammatories that are Food and Drug Administration (FDA)-approved or medically accepted for the patient's diagnosis or indication?

☐ Yes ☐ No

Q2. Is the requested drug an intravitreal implant or injection?

☐ Yes ☐ No

Q3. Is the requested drug being prescribed for an indication that is included in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q4. Is the patient age-appropriate according to the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Ophthalmics - Anti-Inflammatories

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:

Q5. Is 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

Q6. Is the requested drug prescribed by an ophthalmologist?

☐ Yes ☐ No

Q7. Additional Information:

_____ _____

Prescriber Signature Date

v2025