Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Angiotensin Modulators

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 this a request for Qbrelis (lisinopril oral solution) or Epaned (enalapril oral solution)?

☐ Yes ☐ No

Q2. Is the patient less than 9 years of age? [Note: Prior Authorization for Qbrelis (lisinopril oral solution) and Epaned (enalapril oral solution) is not required for patients under 9 years of age.]

☐ Yes ☐ No

Q3. Is this a request for a drug containing aliskiren?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q5. Does the patient have a documented diagnosis of uncontrolled hypertension despite treatment with the following drug classes at maximally tolerated Food and Drug Administration (FDA) approved doses unless contraindicated: A) calcium channel blockers, B) beta blockers, C) diuretics, D) angiotensin-converting enzyme (ACE) inhibitors, E) angiotensin receptor blockers (ARBs)?

☐ Yes ☐ No

Q6. Is this a request for a preferred angiotensin modulator drug?

☐ Yes ☐ No

Q7. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the

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Patient Name:	Prescriber Name:

preferred angiotensin modulator?

☐ Yes ☐ No

Q8. Is this a request for an angiotensin modulator drug when there is a record of a recent paid claim for an angiotensin modulator combination drug or another angiotension modulator drug (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q9. Is the patient being titrated to, or tapered from, another angiotensin modulator or angiotensin modulator combination?

☐ Yes ☐ No

Q10. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q11. Additional Information:

Prescriber Signature

Date

Updated for 2023