HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Enzyme Replacements - Gaucher Disease

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 initial therapy with the requested agent?
[If no, skip to question 12.]

☐ Yes ☐ No

Q2. Is the requested drug being used for the treatment of 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. Is the prescribed dose consistent with Food and Drug Administration (FDA) – approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Does the patient have a history of contraindication to the requested drug?

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Member Name:	Prescriber Name:

☐ Yes ☐ No

Q6. Is the requested medication prescribed by or in consultation with a specialist in the treatment of Gaucher disease?

☐ Yes ☐ No

Q7. Is this request for a non-preferred agent?

☐ Yes ☐ No

Q8. Has the patient tried and failed or had a contraindication or intolerance to the preferred agents approved or medically accepted for the patient's indication?

☐ Yes ☐ No

Q9. Does the patient have a diagnosis of Gaucher disease?

☐ Yes ☐ No

Q10. Does the patient have one of the following: A) Enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) activity, B) Deoxyribonucleic acid (DNA) testing confirming the diagnosis? Note: Please attach documentation of the lab test.

☐ Yes ☐ No

Q11. Does the patient have a diagnosis of one of the following: A) Anemia, B) Bone disease, C) Hepatomegaly, D) Interstitial lung disease, E) Splenomegaly, F) Thrombocytopenia? Note: Please attach documentation.

☐ Yes ☐ No

Q12. Has the plan previously approved the requested drug for this patient (previous authorization is on file under this plan)?

☐ Yes ☐ No

Q13. Is the prescribed dose consistent with Food and Drug Administration (FDA) – approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

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☐ Yes ☐ No

Q14. Is the requested medication prescribed by or in consultation with a specialist in the treatment of Gaucher disease?

☐ Yes ☐ No

Q15. Has the disease severity improved since initiating treatment with the requested drug? Note: Please provide documentation of disease improvement.

☐ Yes ☐ No

Q16. Additional Information:

_____ _____

Prescriber Signature Date

v2025