

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Leukotriene Modifiers

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 montelukast granules?				
□ Yes	□ No			
Q2. Is the patient less than 2 years of age? [Note: Prior Authorization is not required for patients less than 2 years of age.]				
□ Yes	□ No			
Q3. Is this a request for a preferred leukotriene modifier (e.g., montelukast tablet, montelukast chewable tablet)?				
□ Yes	□ No			
Q4. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred leukotriene modifier (e.g., montelukast tablet, montelukast chewable tablet)?				
□ Yes	□ No			
Q5. Is this a request for a leukotriene modifier when there is a record of a recent paid claim for another leukotriene modifier (i.e., potential therapeutic duplication)?				

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Leukotriene Modifiers

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:		
□ Yes	□ No		
Q6. Is the patient being titrated to, or tapered from, a drug in the same class?			
□ Yes	□ No		
Q7. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?			
□ Yes	□ No		
Q8. Additional Information:			

Prescriber Signature

Date

v2025