Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Estrogens

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 the requested medication being used for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q2. Is the patient prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Does the patient have a history of contraindication to the requested medication?

☐ Yes ☐ No

Q4. Is the requested medication being used for gender dysphoria?

☐ Yes ☐ No

Q5. Is the requested medication being prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q6. Is the requested medication being prescribed in a manner consistent with the current World Professional Association for Transgender Health standards of care for the health of transgender and gender diverse people?

☐ Yes ☐ No

Q7. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred estrogen drugs?

☐ Yes ☐ No

Q8. Additional Information:

_____ _____

Prescriber Signature Date

v2025