HEALTH PARTNERS PLANS

PRIOR AUTHORIZATION REQUEST FORM

Oncology Agents - Breast Cancer

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 letrozole or Femara?

☐ Yes ☐ No

Q2. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication? [Note: Documentation from the medical record of the diagnosis is required for approval.]

☐ Yes ☐ No

Q3. Is the requested drug being prescribed to promote fertility?

☐ Yes ☐ No

Q4. Is this a request for a preferred breast cancer oncology drug?

☐ Yes ☐ No

Q5. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred breast cancer oncology drugs?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q6. Additional Information:

______________________________ ____________________

Prescriber Signature Date

v2025

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