

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Benign Prostatic Hyperplasia (BPH) Treatments

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:						
		onths but may be less depending	a on the drug				
	<u></u>		<i>y</i>				
Please attach any pertinent medical history	_		mber that may support approval.				
Please	answer the fol	lowing questions and sign.					
Q1. Is this a request for a phosphodiesteras	Q1. Is this a request for a phosphodiesterase-5 (PDE5) inhibitor (e.g., tadalafil)?						
☐ Yes ☐ No Q2. Does the patient have a diagnosis of benign prostatic hyperplasia (BPH)?							
				Yes	ingii prootatio	□ No	
Q3. Is this a request for an alpha blocker what a 5-alpha reductase inhibitor when there is							
therapeutic duplication)?							
Yes		□ No					
Q4. Is the patient being titrated to or tapered from another drug with the same mechanism of action?							
☐ Yes ☐ No Q5. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?							
				☐ Yes ☐ No			
				Q6. Is this a request for a preferred benign prostatic hyperplasia (BPH) agent?			
Yes		□ No					
Q7. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred b prostatic hyperplasia (BPH) agents?							

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Patient Name:		Prescriber Name:	
	☐ Yes	□ No	
	Q8. Additional Information:		
	Prescriber Signature		Date

Updated for 2023