

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.

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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 Pharmac	y (if applicable):	
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:	Tronno.		
Diagnosis Code: Diagnosis:		de la cardina de la calque	
HPP's maximum approval time is 12 i	months but may be less t	repending on the drug.	
Please attach any pertinent medical history including la	abs and information for	this member that may support approval.	
	following questions and		
Q1. Is this a request for letrozole or Femara?			
Yes			
Q2. Is the patient being treated for a diagnosis that is in package labeling OR a medically accepted indication?	dicated in the Food an	d Drug Administration (FDA) approved	
[Note: Documentation from the medical record of the dia	agnosis is required for	approval.]	
Yes	☐ No		
Q3. Is the requested drug being prescribed to promote f	fertility?		
☐Yes	☐ No		
Q4. Is this a request for a preferred breast cancer oncol	logy drug?		
Yes	□No		
Q5. Does the patient have a history of therapeutic failur cancer oncology drugs?	e, contraindication to,	or intolerance of the preferred breast	
Yes	□No		
Q6. Additional Information:			
Prescriber Signature		Date	

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Updated for 2023