

## HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

## Non-Preferred Drug (non-PDL)

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			
Diagnosis Code:  Diagnosis:  HPP's maximum approval time is 12 months but may be less depending on the drug.			a on the drug	
пер з тахітит арргоха	ai ume is 12 mo	ontris but may be less depending	g 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. Has the patient been treated previously with the requested medication? [If no, then skip to question 7.]				
☐ Yes ☐ No				
Q2. Has the patient received samples of the requested medication? [If no, then skip to question 4.]				
Yes		□ No		
Q3. Has a sample log for the requested medication been attached including dates, dosage, and directions?				
☐Yes		□ No		
Q4. Has the patient been treated on the requested medication while in a hospital or facility? [If yes, then skip to question 6.]				
☐ Yes		□ No		
Q5. Has the patient received the requested medication through means other than samples or a hospital/facility (e.g., through another insurer)?				
☐ Yes ☐ No				
Q6. Are medical records attached showing the requested medication being filled, including dates, dosage, and directions?				
☐ Yes ☐ No				
Q7. Does the requested medication have step therapy requirements?				

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

## Non-Preferred Drug (non-PDL)

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:
[If no, then skip to question 9.]	
☐ Yes	□ No
Q8. Has the patient tried and failed the medication(s) req	uired for step therapy?
☐ Yes	□ No
Q9. Is the requested medication being used for a Food a use supported by nationally recognized pharmacy compe	nd Drug Administration (FDA) approved indication OR for a endia or peer-reviewed medical literature?
☐ Yes	□ No
Q10. Please provide diagnosis:	
Q11. Is this a request for a formulary medication? [If yes, then skip to question 12.]	
☐ Yes	□ No
Q12. Has the patient tried and failed the formulary alternation [Note: If yes, then please provide documentation of the nation the dates of trial.]	atives? nedication(s) tried, the adverse outcome or type of failure, and
☐Yes	□ No
Q13. Are any relevant labs or diagnostic test results for the	he requested medication attached?
☐ Yes	□ No
Q14. Additional Information:	
Prescriber Signature	 Date

Updated for 2023