HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Non-Formulary

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. 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)?

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Member Name:	Prescriber Name:

☐ 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?
[If no, then skip to question 9.]

☐ Yes ☐ No

Q8. Has the patient tried and failed the medication(s) required for step therapy?

☐ Yes ☐ No

Q9. Is the requested medication being used for a Food and Drug Administration (FDA) approved indication OR for a use supported by nationally recognized pharmacy compendia 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 alternatives?
[Note: If yes, then please provide documentation of the medication(s) tried, the adverse outcome or type of failure, and the dates of trial.]

☐ Yes ☐ No

Q13. Are any relevant labs or diagnostic test results for the requested medication attached?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q14. Additional Information:

Prescriber Signature

Date

v2025