HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Quantity Limit Exceptions

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. Does the provider offer clinical rationale to substantiate why Health Partners' quantity limit is not adequate to treat the patient based on condition and treatment history? (Please attach supporting documentation).

☐ Yes ☐ No

Q2. Is the quantity requested at a dose that is within prescribing guidelines but exceeds Health Partners' quantity limits?

☐ Yes ☐ No

Q3. Can the requested drug therapy be satisfied within the plan's quantity limits at a different strength of the same drug?

☐ Yes ☐ No

Q4. Does the patient have a documented history of treatment failure with the requested drug being prescribed within Health Partners' quantity limits?

☐ Yes ☐ No

Q5. Would a trial of the requested drug within Health Partners' quantity limits be detrimental to your patient's health? (Please attach explanation).

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Quantity Limit Exceptions

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:

☐ Yes ☐ No

Q6. Is the quantity requested to treat your patient's condition at a dose that can be medically supported (by recognized compendia, peer-reviewed literature, or standard of care guidelines)? (Please attach supporting documentation).

☐ Yes ☐ No

Q7. Additional Information:

Prescriber Signature

Date

v2025