

Xdemy - 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.

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:	
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

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. Is the request for reauthorization? If YES, go to question 2. If NO, go to question 3.

☐ Yes

☐ No

Q2. Is there peer-reviewed medical literature supporting length of treatment requested?

☐ Yes

☐ No

Q3. Is the patient greater than or equal to 18 years of age?

☐ Yes

☐ No

Q4. Is the drug being prescribed by or in consultation with a specialist (ophthalmologist, optometrist, dermatologist or specialist in treatment of diagnosis)?

☐ Yes

☐ No

Q5. Is there documentation of diagnosis of Demodex blepharitis?

☐ Yes

☐ No

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Member Name:

Prescriber Name:

Q6. Does the patient demonstrate one of the following signs of Demodex infestation: cylindrical cuff at the root of eyelashes, eyelash loss, redness at the lid margin, eyelash misdirection, collarettes?

☐ Yes☐ No

Q7. Does the patient demonstrate two of the following symptoms of Demodex infestation: itching/burning, foreign body sensation, crusting on lashes, tearing/lacrimation, dryness, purulence/discharge, blurry vision, irritation/discomfort?

☐ Yes☐ No

Q8. Additional Information:

Prescriber Signature_____
Date

v2025