



**HEALTH PARTNERS PLANS**  
**PRIOR AUTHORIZATION REQUEST FORM**

**Continuous Glucose Monitors (CGMs)**

**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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
<b>Drug Name:</b>	<b>Strength:</b>	
<b>Quantity:</b>	<b>Refills:</b>	
<b>Directions:</b>		
<b>Diagnosis Code:</b>	<b>Diagnosis:</b>	
<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. The member has a diagnosis of diabetes.**

Yes  No

**Q2. The request is for a preferred Continuous Glucose Monitoring Product.**

Yes  No

**Q3. For a non-preferred Continuous Glucose Monitoring Product, one of the following:**

Has a history of therapeutic failure of the preferred Continuous Glucose Monitoring Products  Requires a non-preferred Continuous Glucose Monitoring Product for compatibility with their insulin delivery device.

**Q4. Additional Information:**

Prescriber Signature

Date

v2026