HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

HYPOGLYCEMICS, DPP-4 INHIBITORS PRIOR AUTHORIZATION FORM *(form effective 1/1/2026)*

Prior authorization guidelines for **Hypoglycemics, DPP-4 Inhibitors** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.

☐New request ☐Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
For ALL Hypoglycemics, DPP-4 Inhibitors: Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to metformin?		☐Yes ☐No *Submit documentation.*	
For a NON-PREFERRED Hypoglycemics, DPP-4 Inhibitor: Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, DPP-4 Inhibitors approved or medically accepted for the beneficiary's diagnosis? *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*		☐Yes ☐No *Submit documentation.*	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: