

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Non-formulary drug

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	s) left blank, illegible, or not attached Wi	LL delay the review process.	
Patient Name:	Prescriber Name:		
Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Address:	NPI:	State Lic ID:	
City, State ZIP:	Address:		
Primary Phone:	City, State ZIP:		
Line of Business: □ Medicaid			
□ CHIP	Specialty/facility name (if applicable)		
□ Expedited/Urgent			
Orug Name:			
Strength: Directions / SIG:			
birections / oto.			
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. What is the requested duration of therapy?			
Q2. Has the patient been treated previously with the medication?			
☐ Yes ☐ No			
Q3. Has the patient received samples of the medication?			
□ Yes □ No			
Q4. Is a sample log attached including dates, dosage, and directions?			
☐ Yes ☐ No			
Q5. Has the patient been treated on this medication while in the hospital or a facility?			
☐ Yes ☐ No			
Q6. Has the patient received the medication through other insurer)?	means other than the above (such	as through another	
□ Yes □ No			
Q7. Are medical records attached showing this medication	being filled including dates, dosag	e, and directions?	
☐ Yes ☐ No			
Q8. Is the medication being used for a FDA approved indication	ation?		
☐ Yes ☐ No			
Q9. What is the diagnosis? (Must attach the diagnosis)			

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Patient Name:		Prescriber Name:
Q10. Has the p	patient tried and failed all formula	ary alternatives?
☐ Yes	□ No	
	edications patient has been treat ate the adverse outcome or type	ated with previously that have resulted in failure or patient intolerance (for e of failure).
Q12. Are the fo	ormulary alternatives that the pat	tient tried and failed listed above?
☐ Yes	□ No	
Q13. Are relev	ant labs or diagnostic test results	s attached?
□ Yes	□ No	
Q14. Additiona	Il Comments:	
	Prescriber Signature	 Date

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