

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Hypoglycemics - SGLT-2 Inhibitors

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.

Patient Name:	Prescriber Name:		
i adentivame.	Trescriber Ivallie.		
HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Patient 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. Is this a request for a non-preferred Hypoglycemic - SGLT2 Inhibitor?			
☐ Yes ☐ No			
Q2. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hypoglycemics - SGLT2 Inhibitors approved or medically accepted for the beneficiary's diagnosis?			
☐Yes	Yes No		
Q3. Is this a request for a Hypoglycemic, SGLT2 Inhibitor SGLT2 Inhibitor?	when there is a paid claim	for another Hypoglycemic -	
☐ Yes	□ No		
Q4. Is the patient being transitioned to or from another Hyone of the medications?	poglycemic - SGLT2 Inhibi	tor with the intent of discontinuing	
☐ Yes	□ No		
Q5. Has the prescriber provided a medical reason for cor by peer-reviewed literature or national treatment guideline		ted medications that is supported	
☐Yes	☐ No		
Q6. Additional Information:			

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Hypoglycemics - SGLT-2 Inhibitors

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.

Patient Name:	Prescriber Name:

Prescriber Signature Date

Updated for 2023