

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Blood Glucose Meter & Test Strips - NONPREFERRED

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.

		p. 00000.
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:		
HPP's maximum approval time is 12 months but may be less depending on the drug.		
THE 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. Testing Frequency:		
Q1. Testing Frequency.		
Q2. Quantity Requested:		
de. danity respective.		
Q3. Is the member pregnant?		
☐Yes	□No	
Q4. Does the member use insulin?		
☐ Yes - Submit documentation	□ No	
Q5. Does the member use an insulin pump?		
☐ Yes - Submit documentation ☐ No		
Q6. If using an insulin pump, are the requested testing supplies the only compatible product for the insulin pump?		

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

Blood Glucose Meter & Test Strips - NONPREFERRED

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:	
☐ Yes - List pump name in Additional Information	□ No	
Q7. Is the member visually impaired?		
☐ Yes	□ No	
Q8. Did the member try the preferred meters/test strips from both of the preferred manufacturers? Indicate meters tried and submit supporting documentation.		
☐ Yes	□ No	
Q9. List meters/test strips tried and failed.		
Q10. Why can't the member use the preferred meters/test strips? Document reason(s) in the space provided and submit supporting documentation.		
Q11. For requests that exceed the quantity limits of 1 meter per 365 days and/or 5 strips per day, document reason(s) for exceeding the quantity limits in the space provided and submit supporting documentation, including testing logs.		
Q12. Additional Information:		
Prescriber Signature	 Date	

v2025