

Non-Preferred Drug - Non-PDL

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):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<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. Has the patient been treated previously with the requested medication?

[If no, then skip to question 7.]

☐ Yes

☐ No

Q2. Has the patient received samples of the requested medication?

[If no, then skip to question 4.]

☐ Yes

☐ No

Q3. Has a sample log for the requested medication been attached including dates, dosage, and directions?

☐ Yes

☐ No

Q4. Has the patient been treated on the requested medication while in a hospital or facility?

[If yes, then skip to question 6.]

☐ Yes

☐ No

Q5. Has the patient received the requested medication through means other than samples or a hospital/facility (e.g., through another insurer)?

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Member Name:	Prescriber Name:
<div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q6. Are medical records attached showing the requested medication being filled, including dates, dosage, and directions? <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q7. Does the requested medication have step therapy requirements? [If no, then skip to question 9.] <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q8. Has the patient tried and failed the medication(s) required for step therapy? <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q9. Is the requested medication being used for a Food and Drug Administration (FDA) approved indication OR for a use supported by nationally recognized pharmacy compendia or peer-reviewed medical literature? <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q10. Please provide diagnosis:	
Q11. Is this a request for a formulary medication? [If yes, then skip to question 12.] <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q12. Has the patient tried and failed the formulary alternatives? [Note: If yes, then please provide documentation of the medication(s) tried, the adverse outcome or type of failure, and the dates of trial.] <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
Q13. Are any relevant labs or diagnostic test results for the requested medication attached? <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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Member Name:

Prescriber Name:

Q14. Additional Information:

Prescriber Signature

Date

v2025