HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Blood Glucose Meter & Test Strips - PRD QL & RTS

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: ☐ 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. Testing Frequency:

Q2. Quantity Requested:

Q3. Is the member pregnant?

☐ Yes ☐ No

Q4. Does the member use insulin?

☐ Yes - submit documentation ☐ No

Q5. Does the beneficiary use an insulin pump?

☐ Yes - Submit documentation ☐ No

Q6. Reason for request:

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Member Name:	Prescriber Name:

☐ Early Refill - Go to 9
☐ Quantity Limit - Go to 7
☐ Other - Please describe in Question 17 - Additional Information. Attach supporting documentation.

Q7. Does the provider offer clinical rationale to substantiate why the plan's quantity limit is not adequate to treat the member based on condition and treatment history? MUST attach supporting documentation.

☐ Yes ☐ No

Q8. Is the quantity requested at a dose that is within prescribing guidelines but exceeds plan quantity limits?

☐ Yes ☐ No

Q9. Does the member require an early refill due to a temporary absence from the Commonwealth OR the United States for an extended period of time that is greater than the remaining day supply of the earlier dispensed medication or medical supplies?

Note: Documentation of the patient's destination and duration of absence is required for approval. If the member is traveling within the United States, an early refill will be dependent on that State's Pharmacy Laws and Regulations.

☐ Yes ☐ No

Q10. Provide dates of travel

Q11. Provide travel location.

Q12. Does the member require an early refill due to a change in therapy? Must provide documentation of a change in dosage of the medication and/or medical supply, an increase in the dosing frequency, or the number of units per dose.

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☐ Yes ☐ No

Q13. Provide the new dose, frequency and/or units.

Q14. Does the member require an early refill because the medication or medical supplies were lost? Must provide documentation describing what medication(s) and/or medical supplies were lost and a description of the event that occurred (when, where, time, date, circumstance).

☐ Yes ☐ No

Q15. Does the member require an early refill because the medication or medical supplies were stolen? Must provide documentation describing what medication(s) and/or medical supplies were stolen, a description of the event that occurred (when, where, time, date, circumstance), and a police report.

☐ Yes ☐ No

Q16. Does the member require an early refill because the medication or medical supplies were destroyed? Must attach documentation describing what medication(s) and/or medical supplies were destroyed, a description of the event that occurred (when, where, time, date, circumstance), and a copy of the insurance report (if the destruction is caused by a natural disaster such as a flood, tornado, or hurricane) or a letter from the Red Cross (if the destruction is caused by fire).

☐ Yes ☐ No

Q17. Additional Information:

Q18. I have attached the necessary documentation for review of this request. I understand by not providing the documentation needed that this request may be delayed or denied.

☐ Yes ☐ No

Prescriber Signature

Date

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