HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Xdemvy - 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: ☐ 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 the request for reauthorization? If YES, go to question 2. If NO, go to question 3.

☐ Yes ☐ No

Q2. Is there medical literature supporting length of treatment requested?

☐ Yes ☐ No

Q3. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q4. Is the drug being prescribed by or in consultation with a specialist (ophthalmologist, optometrist, dermatologist or specialist in treatment of diagnosis)?

☐ Yes ☐ No

Q5. Is there documentation of Demodex blepharitis diagnosis determined by mild redness of upper eyelid and presence of mites upon eyelid exam with presence of collarettes?

☐ Yes ☐ No

Q6. Additional Information:

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Member Name:	Prescriber Name:

Prescriber Signature _____ Date _____

v2025