



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

HUMULIN® R U-500 VIAL

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.

Form with two columns: Patient Name and Prescriber Name. Fields include Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Fax, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, and Specialty/facility name.

Expedited/Urgent checkbox

Drug Name:

Strength:

Days Supply:

Number of Refills:

Directions / SIG:

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. Does the patient have a diagnosis of type 1 or type 2 diabetes mellitus?

Yes checkbox

No checkbox

Q2. Does the request include documentation of the patient's complete insulin regimen, including doses per day, units per dose, and total units per day?

Yes checkbox

No checkbox

Q3. Does the patient require a total dose of at least 200 units of insulin per day?

Yes checkbox

No checkbox

Q4. Has the prescriber provided clinical rationale supporting the use of Humulin® R U-500 vial over the Humulin® R U-500 Kwikpen?

Yes checkbox

No checkbox

Q5. Has the patient been counseled on the appropriate dosing of Humulin® R U-500 insulin, including the differences between it and Humulin® R U-100 insulin, the observation of appropriate syringe unit markings when drawing a dose, and/or instruction to use the U-500-specific insulin syringe?

Yes checkbox

No checkbox

Q6. Requested Duration:

6 Months checkbox

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Patient Name:

Prescriber Name:

Q7. Additional Information:

Prescriber Signature

Date

Updated 2018