Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Non-formulary drug

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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid		
□ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

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. Has the patient been treated previously with the medication?
☐ Yes ☐ No

Q2. Has the patient received samples of the medication?
☐ Yes ☐ No

Q3. Is a sample log attached including dates, dosage, and directions?
☐ Yes ☐ No

Q4. Has the patient been treated on this medication while in the hospital or a facility?
☐ Yes ☐ No

Q5. Has the patient received the medication through other means other than the above (such as through another insurer)?
☐ Yes ☐ No

Q6. Are medical records attached showing this medication being filled including dates, dosage, and directions?
☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q7. Is the medication being used for a FDA approved indication or for use supported by nationally recognized pharmacy compendia, or peer-reviewed medical literature? (Diagnosis must be attached)

☐ Yes ☐ No

Q8. Has the patient tried and failed all formulary alternatives?

☐ Yes ☐ No

Q9. Are the formulary alternatives, that the patient tried and failed, listed (for each medication please state the adverse outcome or type of failure and dates of trial)?

☐ Yes ☐ No

Q10. Are relevant labs or diagnostic test results attached?

☐ Yes ☐ No

Q11. Additional Comments:

Q12. Requested duration:

☐ 3 months
☐ 6 months
☐ 12 months
☐ Other:_____

_____ _____

Prescriber Signature Date

Updated 2018