



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Oral Antidiabetic Agents

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 HPP 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 (if applicable).

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. Is the patient at least 18 years of age?

Yes checkbox

No checkbox

Q2. Does the patient have a diagnosis of Diabetes Mellitus Type II?

Yes checkbox

No checkbox

Q3. Has the patient been treated with metformin or a combination metformin product for at least three months and not reached glycemic control OR has a documented intolerance and/or contraindication to metformin therapy?

Yes checkbox

No checkbox

Q4. What was the last A1c level result?

Q5. What is the date of the last A1c?

Q6. Does the patient have a hemoglobin A1c less than or equal to 9%?

Yes checkbox

No checkbox

Q7. Has the patient failed treatment with at least one formulary alternative such as metformin, sulfonylurea (e.g. glipizide/glipizide ER, glimepiride, glyburide), thiazolidinedione (e.g. pioglitazone), meglinitide, DPP-4 inhibitor (e.g. Januvia), SGLT2 inhibitor (e.g. Jardiance), GLP-1 receptor agonist (e.g. Trulicity), or basal insulin for at least three

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Patient Name:

Prescriber Name:

months OR intolerance OR without reaching glycemic control?

Yes checkbox

No checkbox

Q8. Does the patient have a hemoglobin A1c less than 10%?

Yes checkbox

No checkbox

Q9. Has the patient been treated with dual therapy with formulary alternative agents such as metformin, sulfonylurea (e.g. glipizide/glipizide ER, glimepiride, glyburide), thiazolidinedione (e.g. pioglitazone), meglinitide, DPP-4 inhibitor (e.g. Januvia), SGLT2 inhibitor (e.g. Jardiance), GLP-1 receptor agonist (e.g. Trulicity), or basal insulin for at least three months OR intolerance OR without reaching glycemic control?

Yes checkbox

No checkbox

Q10. Does the patient have a hemoglobin A1c greater than or equal to 10% and/or blood glucose levels greater than or equal to 300 mg/dL?

Yes checkbox

No checkbox

Q11. Has the patient been treated with or have a contraindication or intolerance to injectable therapy (such as insulin and/or Trulicity) therapy? Please list all contraindications to formulary injectable therapy.

Yes checkbox

No checkbox

Q12. Has the requested medication been adjusted based on the patient's current renal function, if appropriate?

Yes checkbox

No checkbox

Q13. Has the patient achieved adequate glycemic control based on most recent ADA/AACE guidelines with current treatment? Please submit documentation of most up-to-date hemoglobin A1c level along with chart notes documenting the goal A1c level and treatment plan.

Yes checkbox

No checkbox

Q14. Duration:

6 months checkbox

Prescriber Signature

Date

Updated 2018