



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Makena

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 fields for Patient Name, HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Prescriber Name, Fax, Phone, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, 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 greater than or equal to 16 years of age?

Yes checkbox

No checkbox

Q2. Is the patient a pregnant female with a single fetus?

Yes checkbox

No checkbox

Q3. Is the patient's pregnancy between 16 weeks, 0 days and 20 weeks, 6 days gestation?

Yes checkbox

No checkbox

Q4. Provide specific gestational age:

Q5. Does the patient have a documented history of a singleton spontaneous preterm birth (prior to 37 weeks gestation)?

Yes checkbox

No checkbox

Q6. Does the patient have any of the following conditions below? A. Current or history of thrombosis or thromboembolic disorders; B. Known or suspected breast cancer, other hormone-sensitive cancer, or history of these conditions; C. Undiagnosed abnormal vaginal bleeding unrelated to pregnancy; D. Cholestatic jaundice of pregnancy; E. Liver tumors, benign or malignant, or active liver disease; F. Uncontrolled hypertension

Yes checkbox

No checkbox

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**Patient Name:**

**Prescriber Name:**

Q7. Is the prescribing physician a specialist (e.g. OB-GYN)?

Yes

No

Q8. Requested Duration:

Up to 36 weeks

Q9. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated 2018*