



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Injectable 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 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 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 a contraindication to metformin therapy?

Yes checkbox

No checkbox

Q4. 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 and is currently being treated with injectable therapy? Please attach most recent hemoglobin A1c.

Yes checkbox

No checkbox

Q5. Has the patient tried and/or is intolerant to therapy with formulary insulin products? Please attach documentation of trial, intolerance or contraindication.

Yes checkbox

No checkbox

Q6. 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

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Patient Name:

Prescriber Name:

(e.g. Januvia), SGLT2 inhibitor (e.g. Steglatro), GLP-1 receptor agonist (e.g. Trulicity), or basal insulin for at least three months with intolerance and/or not reaching glycemic control? If the requested medication is for a GLP-1 receptor agonist, please provide documentation of intolerance to or contraindication with formulary alternative Trulicity.

Yes

No

Q7. 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

No

Q8. Requested Duration:

6 Months

Q9. Additional Information:

Prescriber Signature

Date

Updated 2018