



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Testosterone Replacement Therapy

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 this request for the treatment of gender dysphoria? (If so, please refer to the Treatment of Gender Dysphoria criteria).

Yes checkbox

No checkbox

Q2. Is the request for a preferred product?

Yes checkbox

No checkbox

Q3. Is the request for a male?

Yes checkbox

No checkbox

Q4. Is the member 18 years old or greater?

Yes checkbox

No checkbox

Q5. Is Androgel being prescribed for the sole use of erectile dysfunction?

Yes checkbox

No checkbox

Q6. Do labs show low testosterone levels on 2 separate occasions? Please include labs and collection dates.

Yes checkbox

No checkbox

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

Testosterone Replacement Therapy

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:

Q7. Does the member have one or more of the following symptoms: fatigue, depression, anemia, gynecomastia, and/or reduced muscle strength?

Yes

No

Q8. Are labs including hematocrit, PSA, LFT's, lipids, being monitored? Please attach labs.

Yes

No

Q9. Are there any contraindications including prostate or breast cancer, hematocrit >50 percent, untreated severe sleep apnea, prostate-specific antigen (PSA) concentration >4.0 mcg/L, or >3.0 mcg/L in high-risk men (African-Americans or men with first-degree relatives with prostate cancer), or uncontrolled heart failure?

Yes

No

Q10. Have possible risks of treatment with testosterone been discussed with the member? Risks include erythrocytosis, exacerbation of prostate cancer, benign prostatic hyperplasia (BPH), and cardiovascular disease.

Yes

No

Q11. Requested Duration:

6 months

Q12. Additional information: _____

Prescriber Signature

Date

Updated 2018