Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Testosterone Replacement Therapy Renewal

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 testosterone level been drawn within the past 12 months? Please attach labs.

☐ Yes ☐ No

Q2. Has testosterone level been restored to normal range (400 to 700 ng/dL [13.9 to 27.7 nmol/L])?

☐ Yes ☐ No

Q3. Are labs including hematocrit, PSA, LFT's, lipids, being monitored? Please attach labs.

☐ Yes ☐ No

Q4. Have symptoms (such as fatigue, depression, anemia, gynecomastia, and/or reduced muscle strength) resolved?

☐ Yes ☐ No

Q5. Requested Duration:

☐ 12

Q6. Additional information:_____

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Patient Name:	**Prescriber Name:**
Prescriber Signature	Date

Updated 2018