Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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. Is the patient at least 18 years of age?

☐ Yes ☐ No

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

☐ Yes ☐ No

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 ☐ No

Q4. Does the patient have a hemoglobin A1c less than or equal to 9% or greater than 1.5% above individualized target?

☐ Yes ☐ No

Q5. 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. Steglatro), GLP-1 receptor agonist (e.g. Trulicity), or basal insulin for at least three months OR intolerance OR without reaching glycemic control?

☐ Yes ☐ No

Q6. Does the patient have a hemoglobin A1c greater than or equal to 10% and/or blood glucose levels greater than or

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equal to 300 mg/dL?

☐ Yes ☐ No

Q7. 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 ☐ No

Q8. Has the requested medication been adjusted based on the patient's current renal function, if appropriate?

☐ Yes ☐ No

Q9. 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

Q10. Requested Duration:

☐ 6 Months

Q11. Additional Information:

Prescriber Signature _____ Date _____

Updated 2018