



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields for Patient Name, HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business, 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 contraindication to metformin therapy?

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

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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Patient Name:

Prescriber Name:

equal to 300 mg/dL?

Yes checkbox

No checkbox

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 checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

Q10. Requested Duration:

6 Months checkbox

Q11. Additional Information:

Prescriber Signature

Date

Updated 2018