Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Oral Antidiabetic Agents 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 the patient been previously approved for the requested oral antidiabetic agent?

☐ Yes ☐ No

Q2. Has the patient achieved adequate glycemic control with current treatment regimen? Please submit documentation of most up-to-date hemoglobin A1c level and A1c goal

☐ Yes ☐ No

Q3. Has the prescriber attached a treatment plan to reach goal hemoglobin A1c including diabetes education, monitoring of compliance, optimization of current medication dosage, lifestyle modifications and nutrition consultation?

☐ Yes ☐ No

Q4. Requested Duration:

☐ 6 Months ☐ 12 Months

Q5. Additional Information:

Prescriber Signature

Date

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Updated 2018

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