Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Hypoglycemics - Incretin Mimetics

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:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
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 a request for a glucagon-like peptide-1 (GLP-1) receptor agonist or dipeptidyl peptidase-4 (DPP-4) inhibitor? [If no, then skip to question 5.]

☐ Yes ☐ No

Q2. Does the patient have the diagnosis of type 2 diabetes mellitus?

☐ Yes ☐ No

Q3. Does the patient have a documented history of a failure to achieve glycemic control using maximum tolerated doses of metformin, as evidenced by the patient's hemoglobin A1c (HbA1c) values?

☐ Yes ☐ No

Q4. Does the patient have a documented history of a contraindication to or intolerance of metformin?

☐ Yes ☐ No

Q5. Is this a request for an amylin analog?

☐ Yes ☐ No

Q6. Is this a request for a renewal of authorization for an amylin analog?

☐ Yes ☐ No

Q7. Does the patient have improved glycemic control, as evidenced by a recent hemoglobin A1c (HbA1c) value?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q8. Does the patient have a diagnosis of type 1 diabetes mellitus?

☐ Yes ☐ No

Q9. Does the patient have a diagnosis of type 2 diabetes mellitus?

☐ Yes ☐ No

Q10. Does the patient have a documented history of a failure to achieve glycemic control using maximum tolerated doses of metformin, as evidenced by the patient's hemoglobin A1c (HbA1c) values?

☐ Yes ☐ No

Q11. Does the patient have a documented history of a contraindication to or intolerance of metformin?

☐ Yes ☐ No

Q12. Has the patient failed to achieve adequate glycemic control despite compliance with optimal insulin therapy, as evidenced by the beneficiary's hemoglobin A1c (HbA1c) values?

☐ Yes ☐ No

Q13. Will the requested amylin analog be prescribed in combination with insulin?

☐ Yes ☐ No

Q14. Is this a request for a preferred incretin mimetic/enhancer drug (e.g., Bydureon, Byetta, Janumet, Janumet XR, Januvia, Jentadueto, Tradjenta, Trulicity, Victoza)?

☐ Yes ☐ No

Q15. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred incretin mimetic/enhancer drugs with the same mechanism of action as the requested drug (e.g., Bydureon, Byetta, Janumet, Janumet XR, Januvia, Jentadueto, Tradjenta, Trulicity, Victoza)?

☐ Yes ☐ No

Q16. Additional Information:

Prescriber Signature

Date

Updated for 2020