



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Non-Preferred Drug (non-PDL)

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: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, Strength, Refills, Specialty Pharmacy.

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 treated previously with the requested medication? [If no, then skip to question 7.]

Yes No

Q2. Has the patient received samples of the requested medication? [If no, then skip to question 4.]

Yes No

Q3. Has a sample log for the requested medication been attached including dates, dosage, and directions?

Yes No

Q4. Has the patient been treated on the requested medication while in a hospital or facility? [If yes, then skip to question 6.]

Yes No

Q5. Has the patient received the requested medication through means other than samples or a hospital/facility (e.g., through another insurer)?

Yes No

Q6. Are medical records attached showing the requested medication being filled, including dates, dosage, and directions?

Yes No

Q7. Does the requested medication have step therapy requirements?

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party.



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Patient Name: Prescriber Name:

[If no, then skip to question 9.]
Yes No

Q8. Has the patient tried and failed the medication(s) required for step therapy?
Yes No

Q9. Is the requested medication being used for a Food and Drug Administration (FDA) approved indication OR for a use supported by nationally recognized pharmacy compendia or peer-reviewed medical literature?
Yes No

Q10. Please provide diagnosis:

Q11. Is this a request for a formulary medication?
[If yes, then skip to question 12.]
Yes No

Q12. Has the patient tried and failed the formulary alternatives?
[Note: If yes, then please provide documentation of the medication(s) tried, the adverse outcome or type of failure, and the dates of trial.]
Yes No

Q13. Are any relevant labs or diagnostic test results for the requested medication attached?
Yes No

Q14. Additional Information:

Prescriber Signature

Date

Updated for 2020