



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 checkbox

No checkbox

Q2. Has the patient received samples of the requested medication?

[If no, then skip to question 4.]

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q4. Has the patient been treated on the requested medication while in a hospital or facility?

[If yes, then skip to question 6.]

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q7. Does the requested medication have step therapy requirements?



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Patient Name:	Prescriber Name:
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[If no, then skip to question 9.] <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Has the patient tried and failed the medication(s) required for step therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q10. Please provide diagnosis:
Q11. Is this a request for a formulary medication? [If yes, then skip to question 12.] <input type="checkbox"/> Yes <input type="checkbox"/> 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.] <input type="checkbox"/> Yes <input type="checkbox"/> No
Q13. Are any relevant labs or diagnostic test results for the requested medication attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q14. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

*Updated for 2020*