



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Quantity Limit Exceptions

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. Does the provider offer clinical rationale to substantiate why Health Partners' quantity limit is not adequate to treat the patient based on condition and treatment history? (Please attach supporting documentation).

Yes checkbox

No checkbox

Q2. Is the quantity requested at a dose that is within prescribing guidelines but exceeds Health Partners' quantity limits?

Yes checkbox

No checkbox

Q3. Can the requested drug therapy be satisfied within the plan's quantity limits at a different strength of the same drug?

Yes checkbox

No checkbox

Q4. Does the patient have a documented history of treatment failure with the requested drug being prescribed within Health Partners' quantity limits?

Yes checkbox

No checkbox

Q5. Would a trial of the requested drug within Health Partners' quantity limits be detrimental to your patient's health? (Please attach explanation).

Yes checkbox

No checkbox

Q6. Is the quantity requested to treat your patient's condition at a dose that can be medically supported (by recognized compendia, peer-reviewed literature, or standard of care guidelines)? (Please attach supporting documentation).

Yes checkbox

No checkbox



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Patient Name:	Prescriber Name:
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Q7. Additional Information:

Prescriber Signature

Date

Updated for 2020