



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Hypoglycemics - SGLT-2 Inhibitors

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.

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 the requested medication being prescribed for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

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. Does the patient require initial dual therapy with metformin based on HbA1c as defined by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology?

Yes No

Q6. For a SGLT2 Inhibitor with proven cardiovascular disease (CVD), heart failure (HF), or chronic kidney disease (CKD) benefit, does the patient have CVD (or two risk factors for CVD as identified by the American Diabetes Association or the American Association of Clinical Endocrinologists and American College of Endocrinology), HF, or CKD?

Yes No



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Patient Name:	Prescriber Name:
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Q7. Is this a request for a preferred SGLT-2 inhibitor?

Yes No

Q8. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred SGLT-2 inhibitors?

Yes No

Q9. Additional Information:

Prescriber Signature

Date

Updated for 2021