



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

PITUITARY SUPPRESSIVE AGENTS - LHRH

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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

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 drug for an indication that is included in the United States (U.S.) Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes

No

Q2. Is the requested drug prescribed at a dose and duration of therapy that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q3. Does the patient have a history of a contraindication to the prescribed medication?

Yes

No

Q4. Is the patient age-appropriate for the requested drug according to the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q5. Does the patient have a diagnosis of gender dysphoria?

Yes

No

Q6. Is the patient an adolescent?

Yes

No

Q7. Is the requested drug prescribed by or in consultation with a pediatric endocrinologist, adolescent medicine specialist, or medical provider with experience and/or training in transgender medicine?

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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the requested drug prescribed in a manner consistent with the current World Professional Association for Transgender Health standards of care for the health of transsexual, transgender, and gender nonconforming people?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the patient an adult?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Is the requested drug prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Is the requested drug prescribed in a manner consistent with current medical literature?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Does the patient have a diagnosis of endometriosis?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Is the diagnosis of endometriosis confirmed by laparoscopy OR supported by chart documentation of an adequate work-up that includes the clinical rationale for the diagnosis?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Does the patient have a history of therapeutic failure, contraindication, or intolerance to non-steroidal anti-inflammatory drugs (NSAIDs), AND therapeutic failure (based on a 3-month trial), contraindication, or intolerance to oral contraceptives?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Is the requested drug prescribed by or in consultation with a gynecologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Is the requested drug Orilissa (elagolix)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Does the patient have a history of depression and/or suicidal thoughts or behaviors or is currently receiving treatment for depression and/or suicidal thoughts or behavior?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Has a behavioral health assessment been performed prior to use of Orilissa (elagolix)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Q19. Is the requested drug being used for the preservation of ovarian function?
Q20. Is the patient receiving cancer treatment that is associated with premature ovarian failure...
Q21. Is the requested drug Oriahnn (elagolix, estradiol, norethindrone, elagolix)?
Q22. Is Oriahnn (elagolix, estradiol, norethindrone, elagolix) being used for the management of heavy menstrual bleeding...
Q23. Does the patient have a history of therapeutic failure...
Q24. Does the patient have a history of depression and/or suicidal thoughts...
Q25. Has a behavioral health assessment been performed prior to use of Oriahnn...
Q26. Is the requested drug a non-preferred agent?
Q27. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred Pituitary Suppressives...
Q28. Additional Information:

Prescriber Signature

Date

Updated for 2021

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