



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Estrogens

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. Is the requested medication being used for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes No

Q2. Is the patient prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes No

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

Yes No

Q4. Is the requested medication being used for gender dysphoria?

Yes No

Q5. Is the requested medication being prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine?

Yes No

Q6. Is the requested medication being 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?

Yes No

Q7. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred estrogen

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Patient Name:	Prescriber Name:
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drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Q8. Additional Information:

Prescriber Signature

Date

Updated for 2022