



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

Progestational Agents

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 PROMSe 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 request for hydroxyprogesterone caproate?

Yes No

Q2. Is the patient a female pregnant with a single fetus?

Yes No

Q3. Is the patient between 16 weeks, 0 days and 36 weeks, 6 days gestation?

Yes No

Q4. Does the patient have a documented history of prior spontaneous preterm singleton birth (defined as prior to 37 weeks gestation)?

Yes No

Q5. Is the requested drug being initiated/was the requested drug being initiated between 16 weeks, 0 days gestation and 20 weeks 6 days gestation?

Yes No

Q6. Does the patient have a history of contraindication to hydroxyprogesterone caproate?

Yes No

Q7. Is the request for a preferred hydroxyprogesterone caproate product (Makena autoinjector, hydroxyprogesterone caproate vial)?

Yes No

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Patient Name:	Prescriber Name:
Q8. Is the request for a non-preferred progestational agent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the medication for intravaginal use? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance of the preferred progestational agents approved or medically accepted for the patient's indication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is the requested intravaginal progestational agent being prescribed for treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration-approved package labeling OR a medically accepted indication, excluding use to promote fertility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Additional Information:	

Prescriber Signature

Date

Updated for 2022