



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Androgenic 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.

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 drug being prescribed 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 a contraindication to the prescribed medication?

Yes No

Q4. Does the patient have a diagnosis of hypogonadism?

Yes No

Q5. Does the patient have clinical and laboratory findings (such as testosterone, luteinizing hormone [LH], follicle-stimulating hormone [FSH]) supporting the diagnosis?

Yes No

Q6. Does the patient have a diagnosis of gender dysphoria?

Yes No

Q7. Is the requested drug prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine



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Patient Name: Prescriber Name:

Form containing questions Q8 through Q15 with Yes/No checkboxes. Q8: Is the requested drug prescribed in a manner consistent with the current World Professional Association for Transgender Health standards... Q9: Is this a request for an androgenic agent when there is a paid claim for another androgenic agent... Q10: Is the patient being titrated to, or tapered from, a drug in the same class? Q11: Has the prescriber provided a medical reason for concomitant use... Q12: Is this a request for a preferred androgenic agent? Q13: Does the patient have a history of therapeutic failure... Q14: Is this a request for a renewal of authorization? Q15: Additional Information:

Prescriber Signature

Date

Updated for 2022