Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
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 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:

☐ Yes	☐ 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?	
☐ Yes	☐ No
Q9. Is this a request for an androgenic agent when there is a paid claim for another androgenic agent (i.e., potential therapeutic duplication)?	
☐ Yes	☐ No
Q10. Is the patient being titrated to, or tapered from, a drug in the same class?	
☐ Yes	☐ No
Q11. Has the prescriber provided a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?	
☐ Yes	☐ No
Q12. Is this a request for a preferred androgenic agent?	
☐ Yes	☐ No
Q13. Does the patient have a history of therapeutic failure of the preferred androgenic agents?	
☐ Yes	☐ No
Q14. Is this a request for a renewal of authorization?	
☐ Yes	☐ No
Q15. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2023

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