



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Early Refills Medical Necessity

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, etc.

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. Does the patient require an early refill due to a temporary absence from the Commonwealth OR the United States for an extended period of time that is greater than the remaining day supply of the earlier dispensed medication or medical supplies?

[Note: Documentation of the patient's destination and duration of absence is required for approval. If the patient is traveling within the United States, an early refill will be dependent on that State's Pharmacy Laws and Regulations.]

Yes No

Q2. Is this a request for a medication that could potentially be detrimental to the patient's health and safety if used in large quantities (e.g., controlled substances, sleep aids, etc.)?

Yes No

Q3. Does the patient require an early refill due to a change in therapy?

[Note: If yes, then documentation of a change in dosage of the medication and/or medical supply, an increase in the dosing frequency, or the number of units per dose is required for approval.]

Yes No

Q4. Does the patient require an early refill because the medication or medical supplies were lost?

[Note: If yes, then documentation describing what medication(s) and/or medical supplies were lost and a description of the event that occurred (when, where, time, date, circumstance) is required for approval.]

Yes No

Q5. Does the patient require an early refill because the medication or medical supplies were stolen?

[Note: If yes, then documentation describing what medication(s) and/or medical supplies were stolen, a description of the event that occurred (when, where, time, date, circumstance), and an attached police report are required for approval.]



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Patient Name: Prescriber Name:

Yes No

Q6. Does the patient require an early refill because the medication or medical supplies were destroyed? [Note: If yes, then documentation describing what medication(s) and/or medical supplies were destroyed, a description of the event that occurred (when, where, time, date, circumstance), and a copy of the insurance report (if the destruction is caused by a natural disaster such as a flood, tornado, or hurricane) or a letter from the Red Cross (if the destruction is caused by fire) is required for approval.]

Yes No

Q7. Does the patient require an early refill for a medication that is life sustaining? [Note: If yes, then the prescriber must provide information that demonstrates that the medication is life sustaining (examples: a diagnosis of HIV, organ transplant) or is indicated for a psychiatric diagnosis (examples: schizophrenia or other mental illness).]

Yes No

Q8. Additional Information:

Prescriber Signature

Date

Updated for 2023