

## HEALTH PARTNERS PLANS 2023 PRIOR AUTHORIZATION REQUEST FORM

## **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:	Prescriber Name:	
HPP HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Patient Primary Phone:	NPI:	PA PROMISe ID:	
Address:	Address:	Address:	
City, State ZIP:	City, State ZIP:	City, State ZIP:	
Line of Business: ð Medicaid ð CHIP		Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	l	
Quantity:	Refills:		
Directions:			
Diagnosis Code: Dia	agnosis:		
HPP's maximum approval tii	me is 12 months but may be less d	epending on the drug.	
Please attach any pertinent medical history inc	cluding labs and information for	this member that may support approval.	
Please ans	wer the following questions and	sign.	
Q1. Is the request for a non-preferred pr	rogestational agent?		
□Yes	□ No		
Q2. Is the medication for intravaginal us	e?		
□Yes	□No		
Q3. Does the patient have a documente intolerance of the preferred progestation indication?	•		
□Yes	□No		
Q4. Is the requested intravaginal proges that is indicated in the U.S. Food and Di medically accepted indication, excluding	rug Administration-approve		
□ Yes	□No		
Q5. Additional Information:			
Prescriber Signature		Date	

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Updated for 2023