HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Hypoglycemics - Insulins and Related 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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member 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 this a request for a nonpreferred Hypoglycemic, Insulin and Related agent that does not contain a glucagon-like peptide-1 (GLP-1) receptor agonist?

☐ Yes ☐ No

Q2. Does the patient have a history of therapeutic failure or contraindication or intolerance to the preferred hypoglycemics, insulin and related agents with the same duration of action or that would not be expected to occur with the requested medication?

☐ Yes ☐ No

Q3. Is this a request for a non-preferred Hypoglycemic, Insulin and Related Agent that contains a GLP-1 receptor agonist?

☐ Yes ☐ No

Q4. Is there a clinical reason why a preferred basal insulin and a preferred GLP-1 receptor agonist cannot be used?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q5. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hypoglycemics - Insulin and Related Agents that contain a GLP-1 receptor agonist?

☐ Yes ☐ No

Q6. Is this a request for Afrezza?

☐ Yes ☐ No

Q7. Is the requested drug being prescribed by or in consultation with an endocrinologist?

☐ Yes ☐ No

Q8. Does the patient have any contraindications to Afrezza?

☐ Yes ☐ No

Q9. Is the patient age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q10. Is this a duplication of a hypoglycemic, insulin or related agent where the patient is being transitioned to another drug or has a medical reason supported by peer-reviewed literature or national treatment guidelines to continue both drugs?

☐ Yes ☐ No

Q11. Additional Information:

Prescriber Signature

Date

v2025