

HEALTH PARTNERS PLANS 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.

OR a medically accepted indication, excluding use to promote fertility? ☐ Yes ☐ No	Member Name:	Prescriber Name:							
Member Primary Phone: Address: City, State ZIP: Line of Business: Medicaid CHIP Specialty Pharmacy (if applicable): Drug Name: Quantity: Directions: Diagnosis Code: Please attach any pertinent medical history including labs and information for this member that may support approper answer the following questions and sign. Q1. Is the request for a non-preferred progestational agent? Yes No Q3. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance of the preferred progestational agents approved or medically accepted for the patient's indication? Yes No Q4. Is the requested intravaginal progestational agent being prescribed for treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration-approved package labelin OR a medically accepted indication, excluding use to promote fertility? Yes No	HPP Member Number:	Fax: Phone:							
Address: City, State ZIP: Line of Business: Medicaid CHIP Specialty Pharmacy (if applicable): Drug Name: Strength: Quantity: Refills: 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 app Please answer the following questions and sign. Q1. Is the request for a non-preferred progestational agent? No Q2. Is the medication for intravaginal use? No Q3. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance of the preferred progestational agents approved or medically accepted for the patient's indication? No Q4. Is the requested intravaginal progestational agent being prescribed for treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration-approved package labelin OR a medically accepted indication, excluding use to promote fertility? Yes No	Date of Birth:	Office Contact:							
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	□Yes	□No							
Q5. Additional Information:									

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	Member Name:					Prescriber Name:		
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