Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Oncology Agents - Breast Cancer

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 this a request for letrozole or Femara?

☐ Yes ☐ No

Q2. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?
[Note: Documentation from the medical record of the diagnosis is required for approval.]

☐ Yes ☐ No

Q3. Is the requested drug being prescribed to promote fertility?

☐ Yes ☐ No

Q4. Is this a request for a preferred breast cancer oncology drug?

☐ Yes ☐ No

Q5. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred breast cancer oncology drugs?

☐ Yes ☐ No

Q6. Additional Information:

Prescriber Signature

Date

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Updated for 2023