HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Acne Agents - Topical

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 topical acne agent with the potential for cosmetic use, such as those with an active ingredient of tretinoin, adapalene, azelaic acid or tazarotene?

☐ Yes ☐ No

Q2. Is the patient 21 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis that confirms the treatment is for a non-cosmetic indication, such as, but not limited to acne, rosacea or plaque psoriasis?

☐ Yes ☐ No

Q4. Is this a request for a preferred topical acne agent?

☐ Yes ☐ No

Q5. Does the patient have a documented history of therapeutic failure, intolerance of, or contraindication to the preferred topical acne agents?

☐ Yes ☐ No

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Acne Agents - Topical

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:

Q6. Additional Information:

Prescriber Signature

Date

v2025