

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Alcohol Use Disorder 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 lab	s and information for this me	mber that may support approval.
Please answer the following questions and sign.		
Q1. Is the requested drug prescribed for treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?		
□Yes	□No	
Q2. Is the patient prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?		
☐ Yes	□ No	
Q3. Is the requested drug a non-preferred alcoh	ol use disorder agent?	
□ Yes	□ No	
Q4. Does the patient have a history of therapeut preferred alcohol use disorder agents?	ic failure, contraindication	on or intolerance to the
☐ Yes	□ No	
Q5. Additional Information:		

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Alcohol Use Disorder 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:
Prescriber Signature	Date

v2025