Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Cephalosporins

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. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred cephalosporin drugs (e.g., cefadroxil capsule, cefdinir oral suspension, cefdinir capsule, cefpodoxime tablet, cefprozil oral suspension, cefprozil tablet, cefuroxime tablet, cephalexin oral suspension, cephalexin 250 mg and 500 mg capsule)?

☐ Yes ☐ No

Q2. Does the patient have culture and sensitivity test results documenting that only the non-preferred cephalosporins will be effective?

☐ Yes ☐ No

Q3. Additional Information:

Prescriber Signature

Date

v2025