HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Hypoglycemics - TZDs

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 non-preferred Hypoglycemic - TZD?

☐ Yes ☐ No

Q2. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred Hypoglycemics - TZDs (pioglitazone)?

☐ Yes ☐ No

Q3. Is this a request for a Hypoglycemic - TZD when there is a paid claim for another Hypoglycemic - TZD (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q4. Is the patient being transitioned to or from another Hypoglycemic - TZD with the intent of discontinuing one of the medications?

☐ Yes ☐ No

Q5. Has the prescriber provided a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q6. Additional Information:

Prescriber Signature

Date

v2025