## Health Partners •••• Medicare

## PRIOR AUTHORIZATION REQUEST FORM

High Risk Meds-Butalbital Combinations - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

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.

Patient Name:	Prescriber Name:		
Member Number:	Fax: Phone:		
Date of Birth:	Office Contact:		
Line of Business:   Medicare	NPI: State Lic ID:		
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable):		
☐ REQUEST FOR EXPEDITED REVIEW: By checking this the life or health of the enrollee or the enrollee's ability t	box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize to regain maximum function.		
Drug Name:			
Strength:  Directions / SIG:			
Directions / SIG:			
Please attach any pertinent medical hi	istory including labs and information for this member that may support approval.		
• •	ease answer the following questions and sign.		
	der? [Note: The Prior Authorization requirement only applies to patients 65 years of required for patients under 65 years of age.]		
Yes	□ No		
Q2. Is this High Risk Medication being	used for a medically accepted indication?		
Yes			
Q3. What is the patient's diagnosis?			
go, mane are parente araginesis.			
Q4. Has a risk-versus-benefit assessme	ent been completed for the High Risk Medication?		
Yes	□ No		
Q5. Has the patient been counseled on	the potential side effects and risks of the requested High Risk Medication?		
Yes	□ No		
O6 Doce the handit autweigh the note	ential risk?		
Q6. Does the benefit outweigh the pote			
Yes	□ No		
Q7. Requested Duration:			
☐ 12 months	Other:		
Q8. Additional Information:			

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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:	Prescr	Prescriber Name:	
Prescriber Signature	re	Date	
		2023 Medicare Prior Authorization Request	