Health Partners •••• Medicare

PRIOR AUTHORIZATION REQUEST FORM

Nayzilam - 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.

PLEASE NOTE: Any information (patient, prescriber, drug. labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
_ine 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	s 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:	
Please attach any pertinent medical h	nistory including labs and information for this member that may support approval.
* •	lease answer the following questions and sign.
Q1. Is the patient 12 years of age or ol	lder?
Yes	□ No
Q2. Is the prescriber a neurologist?	
Yes	□ No
Q3. Does the patient have acute narro	ww-angle glaucoma?
Yes	□ No
O4 to there decumentation chewing the	and the medication is being used for an EDA approved indication not otherwise
excluded from Part D?	nat the medication is being used for an FDA-approved indication not otherwise
☐Yes	□ No
Q5. Requested Duration:	
☐ 12 Months	
Q6. Additional Information:	
Qu. Additional information.	
Prescriber Signature	Date
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