Health Partners •••• Medicare

PRIOR AUTHORIZATION REQUEST FORM

Regranex - 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:	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 nam	e (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this the life or health of the enrollee or the enrollee's ability to Drug Name: Strength:		ur standard review timeframe may seriously jeopardize	
Directions / SIG:			
	istory including labs and information for t ease answer the following questions and s		
	e treatment of lower extremity diabetic ne		
☐ Yes	□No		
Q2. Is the patient 16 years of age or old	der?		
☐Yes	□No		
Q3. Additional Information:			
Q4. Requested Duration:			
☐ 5 months	☐ Other		
Prescriber Signature		Date	
	2	2023 Medicare Prior Authorization Reques	

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