Health Partners •••• Medicare

PRIOR AUTHORIZATION REQUEST FORM

Filgrastim Agents - 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, p	rescriber, drug, labs) left blank, illegible, or not attached WILL delay the revi	ew 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 because the life or health of the enrollee or the enrollee's ability to	${\sf x}$ and signing below, I certify that applying the 72 hour standard review timeframe may egain maximum function.	seriously jeopardize
Drug Name:		
Strength:		
Directions / SIG:		
• •	ory including labs and information for this member that may suppose answer the following questions and sign.	rt approval.
Q1. Is this medication being used a medi	cally accepted indication not otherwise excluded from Part D?	
☐ Yes	□ No	
Q2. Are chart notes or documentation pro accepted indication not otherwise exclud	ovided to support that the medication is being used for a specified ed from Part D?	l medically
☐ Yes	□ No	
	ab work (CBC with differential including ANC) is being monitored mmendations for that specific diagnosis?	prior to
☐ Yes	□ No	
Q4. Will chart notes be provided that sho based on recommendations for that spec	w that lab work (CBC with differential, ANC) is being monitored dific diagnosis?	uring therapy
☐ Yes	□ No	
Q5. Requested Duration:		
☐ 6 months		
Q6. Additional Information:		
Prescriber Signature	 Date	

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



PRIOR AUTHORIZATION REQUEST FORM

Filgrastim Agents - 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:

2023 Medicare Prior Authorization Request