## Health Partners •••

## PRIOR AUTHORIZATION REQUEST FORM

**Oral Oncology 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:		
Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:	Office Contact:	
Line of Business: 🛛 Medicare	NPI:	State Lic ID:	
Address:	Address:	Address:	
City, State ZIP:	City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility na	Specialty/facility name (if applicable):	

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

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 the requested medication being used for a medically accepted indication not otherwise excluded from Part D? Please provide documentation of diagnosis.			
☐ Yes	□ No		
Q2. Requested Duration:			
☐ 12 Months	☐ Other		
Q3. Additional Information:			

Prescriber Signature

Date

2023 Medicare Prior Authorization Request

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