Health Partners •••• Medicare

PRIOR AUTHORIZATION REQUEST FORM

Gattex - 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	<u>:</u>	
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	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By che the life or health of the enrollee or the enrolle		72 hour standard review timeframe may seriously jeopardize	
Drug Name:			
Strength:			
Directions / SIG:			
Please attach any pertinent m	edical history including labs and information Please answer the following questions a		
Q1. Is this a request for continu		ind Sign.	
Yes	□No		
Q2. Is there documentation sho support?	owing a diagnosis of short bowel syndrome a	and patient is dependent on parenteral	
Yes	□No		
Q3. Is there documentation of r	eduction in parenteral support?		
Yes	□No		
Q4. Requested Duration:			
☐ 12 months			
Q5. Additional Information:			
Prescriber Si	gnature	Date	
		2023 Medicare Prior Authorization Reques	

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