

PRIOR AUTHORIZATION REQUEST FORM

Part B vs D: Injectables - 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.

atient Name:	Prescriber Name:
/lember 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):
he life or health of the enrollee or the enrollee's ability t	box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize o regain maximum function.
Strength:	
Directions / SIG:	
	story including labs and information for this member that may support approval.
Ple	ase answer the following questions and sign.
Q1. Is the requested drug being supplie service (i.e., the drug is being furnished	ed from the physician and/or office stock supply and billed as part of a physician I "incident to a physician's service")?
☐ Yes	□ No
Q2. Additional Information:	
Q3. Duration:	
☐ 12 Months	☐ Other
Prescriber Signature	Date
	2023 Medicare Prior Authorization Reques

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