Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Part B vs D: Infusion Pump Drugs - 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:
Line 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 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 drug being administered via an infusion pump (excluding disposable pump)?
[Note: If using a disposable pump, answer is NO since drugs via a disposable pump are covered under Part D.]

☐ Yes ☐ No

Q2. Is the requested drug being administered via an infusion pump in the home (e.g., PATIENT'S HOME, NOT A FACILITY)?
If Yes, go to 6.

☐ Yes ☐ No

Q3. Does the patient reside in one of the following skilled nursing facilities (SNF)/skilled care facilities:
A) A nursing home that is dually-certified as both a Medicare skilled nursing facility and a Medicaid nursing facility (NF),
B) A Medicaid-only NF that primarily furnishes skilled care,
C) A non-participating nursing home (i.e., neither Medicare nor Medicaid) that provides primarily skilled care,
D) An institution which has a distinct part SNF and which also primarily furnishes skilled care?
If No, go to 6.

☐ Yes ☐ No

Q4. Is Medicare Part A paying for the facility bed during the days this treatment is being requested?

☐ Yes ☐ No

Q5. Is the requested drug being supplied from the physician and/or office stock supply and billed as part of a physician service (i.e., the drug is being furnished "incident to a physician's service")?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Is the requested drug a narcotic analgesic for a non-cancer diagnosis?

☐ Yes ☐ No

Q7. Additional Information:

Q8. Duration:

☐ 12 Months ☐ Other

Prescriber Signature

Date

2023 Medicare Prior Authorization Request