Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Part B vs D: Oral Chemo/Immunosup Agent - CARE

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 Methotrexate (excluding 2.5mg tablets) or Cyclophosphamide being used as treatment for cancer?

☐ Yes ☐ No

Q2. Is the oral chemotherapy formulation being used for the same indication as the injectable chemotherapy formulation?

☐ Yes ☐ No

Q3. Is this medication being used as a component of an immunosuppressive regimen for an organ transplant?

☐ Yes ☐ No

Q4. Additional Information:

Q5. Duration:

☐ 12 Months ☐ Other

Prescriber Signature

Date

2023 Medicare Prior Authorization Request