Health Partners •••• Medicare

PRIOR AUTHORIZATION REQUEST FORM

Part B vs D: Oral Antiemetic 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:
_ine 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 he life or health of the enrollee or the enrollee's ability	s box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize to regain maximum function.
Drug Name:	
Strength:	
Directions / SIG:	
	istory including labs and information for this member that may support approval. ease answer the following questions and sign.
Q1. Is the oral antiemetic agent being u	used as part of a cancer chemotherapy regimen?
Yes	□ No
	be used as a full therapeutic replacement for an intravenous antiemetic otherapy or within 24 hours of chemotherapy if dolasetron or granisetron?
☐ Yes	□ No
	following: A) more than 24 hours of oral antiemetic therapy of dolasetron or therapy of another requested oral antiemetic drug (excluding dolasetron or
☐Yes	□ No
Q4. Additional Information:	
Q5. Requested Duration	
12 Months	
Prescriber Signature	
	2023 Medicare Prior Authorization Reques

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