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:
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 oral antiemetic agent being used as part of a cancer chemotherapy regimen?

☐ Yes ☐ No

Q2. Will the oral antiemetic formulation be used as a full therapeutic replacement for an intravenous antiemetic administration within 48 hours of chemotherapy or within 24 hours of chemotherapy if dolasetron or granisetron?

☐ Yes ☐ No

Q3. Will the patient require one of the following: A) more than 24 hours of oral antiemetic therapy of dolasetron or granisetron, B) more than 48 hours of therapy of another requested oral antiemetic drug (excluding dolasetron or granisetron)?

☐ Yes ☐ No

Q4. Additional Information:

Q5. Requested Duration

☐ 12 Months

Prescriber Signature Date

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