## Health Partners •••• Medicare

## PRIOR AUTHORIZATION REQUEST FORM

## Topical Retinoids - 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 the life or health of the enrollee or the enrollee.			r standard review timeframe may seriously jeopardize
Drug Name:			
Strength: Directions / SIG:			
Directions / Sig.			
	Please answer th	e following questions and si	is member that may support approval. gn. not otherwise excluded from Part D?
Yes		□ No	
Q2. Please list indication for	use.		
Q3. Are the chart notes docu	ımenting the patient's dia	agnosis attached? Please a	tach.
Yes		☐ No	
Q4. Additional Information:			
Q5. Duration:			
☐ 12 months		☐ Other	
Prescribe	r Signature		Date
. 10001100		2(	023 Medicare Prior Authorization I

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