Health Partners •••• Medicare

PRIOR AUTHORIZATION REQUEST FORM

Valtoco - 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 the life or health of the enrollee or the enrollee's ability	nis box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize y 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 patient 6 years of age or old	der?
Yes	□ No
Q2. Is the prescriber a neurologist?	
Yes	□ No
Q3. Does the patient have acute narro	
Yes	□ No
Q4. Is there documentation showing t excluded from Part D?	that the medication is being used for an FDA-approved indication not otherwise
☐ Yes	□ No
Q5. Additional Information:	
Q6. Requested Duration:	
☐ 12 Months	☐ Other
Prescriber Signature	e Date
Ç	2023 Medicare Prior Authorization Reques

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