

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: <input type="checkbox"/> 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.**

<p>Q1. Is the patient 65 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is this High Risk Medication being used for a medically accepted indication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. What is the diagnosis?</p>
<p>Q4. Has a risk-versus-benefit assessment been completed for the High Risk Medication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Has the patient been counseled on the potential side effects and risks of the requested High Risk Medication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the benefit outweigh the potential risks?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested drug being prescribed for the treatment of allergic conditions?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Has the patient had an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as levocetirizine, desloratadine, azelastine nasal spray, fluticasone propionate nasal spray, or mometasone nasal spray?</p>

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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Requested Duration:	<input type="checkbox"/> Other
<input type="checkbox"/> 12 Months	
Q10. Additional Information:	

Prescriber Signature

Date

2023 Medicare Prior Authorization Request