## Health Partners •••• Medicare

## PRIOR AUTHORIZATION REQUEST FORM

Lucemyra - 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):
	<u>DITED REVIEW</u> : By checking this box and signing below the enrollee's ability to regain maximum f	ow, I certify that applying the 72 hour standard review timeframe may seriously jeopardize 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 18 years of age or older?		
☐ Yes		□ No
Q2. Does the patient have a diagnosis of acute opioid withdrawal documented by an opioid withdrawal scale (such as Objective Opioid Withdrawal Scale [OOWS], Clinical Opioid Withdrawal Scale [COWS], Subjective Opioid Withdrawal Scale [SOWS])?Chart notes must be attached.		
☐ Yes		□ No
Q3. Does the patient have documentation of an inadequate response, inability to tolerate, or contraindication to clonidine?		
☐ Yes		□ No
Q4. Requested	Duration:	
☐ 14 Days		
Q5. Additional I	nformation:	
	Prescriber Signature	Date
		2023 Medicare Prior Authorization Request

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