Health Partners •••• Medicare

PRIOR AUTHORIZATION REQUEST FORM

Rezurock - 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 si the life or health of the enrollee or the enrollee's ability to regain m	igning below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize naximum function.
Drug Name:	
Strength:	
Directions / SIG:	
	ncluding labs and information for this member that may support approval.
	swer the following questions and sign.
	ved Indication not otherwise excluded from Part D?
☐ Yes	□ No
Q2. Is the patient 12 years of age or older?	
Yes	□ No
Q3. Is the drug prescribed by or in consultation specialist?	n with an oncologist, hematologist, or bone marrow transplant
Yes	□ No
Q4. Is the patient female of childbearing age of	r male with female partners of reproductive potential?
Yes	□ No
Q5. Has confirmation been provided that effect	tive contraception will be used during treatment?
Yes	□ No
Q6. Has confirmation of a trial and failure of at disease been provided?	least 2 conventional systemic treatments for chronic graft-versus-host
Yes	□ No
Q7. Duration:	
☐ 12 months	☐ Other

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Patient Name:	Prescriber Name:
Q8. Additional Information:	
Prescriber Signature	Date 2023 Medicare Prior Authorization Request