Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Sympazan - 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 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.

Q1. Is Sympazan being used for a medically accepted indication not otherwise excluded from Part D?

☐ Yes ☐ No

Q2. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q3. Is there documentation attached of an inadequate response or inability to tolerate generic clobazam?

☐ Yes ☐ No

Q4. Is there documentation attached showing that Sympazan will be used as adjunctive therapy to other antiepileptic drugs?

☐ Yes ☐ No

Q5. Additional Information:

Q6. Duration:

☐ 12 months ☐ Other:

Prescriber Signature

Date

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