Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Filgrastim Agents - 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 this medication being used a medically accepted indication not otherwise excluded from Part D?

☐ Yes ☐ No

Q2. Are chart notes or documentation provided to support that the medication is being used for a specified medically accepted indication not otherwise excluded from Part D?

☐ Yes ☐ No

Q3. Are chart notes provided that show lab work (CBC with differential including ANC) is being monitored prior to initiation of the medication based on recommendations for that specific diagnosis?

☐ Yes ☐ No

Q4. Will chart notes be provided that show that lab work (CBC with differential, ANC) is being monitored during therapy based on recommendations for that specific diagnosis?

☐ Yes ☐ No

Q5. Requested Duration:

☐ 6 months

Q6. Additional Information:

Prescriber Signature

Date

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