## Health Partners •••• Medicare

## PRIOR AUTHORIZATION REQUEST FORM

Endari - 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.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
_ine 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 be he life or health of the enrollee or the enrollee's ability to	pox and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize oregain maximum function.
Drug Name:	
Strength:	
Directions / SIG:	
Please attach any pertinent medical hi	story including labs and information for this member that may support approval.
* ·	ase answer the following questions and sign.
Q1. Does the patient have a diagnosis of	of sickle cell disease? Chart notes must be attached
☐ Yes	□ No
Q2. Is the request to reduce acute comp	olications of sickle cell disease?
☐ Yes	□ No
Q3. Is there documentation of an inaded contraindication to hydroxyurea therapy	quate response to maximum tolerated dose of hydroxyurea OR intolerance OR ?
☐ Yes	□ No
Q4. Is the requested dose within the FD	A labeled dose?
Yes	□ No
Q5. Will Endari be prescribed by a hema	atologist or oncologist?
☐ Yes	□ No
Q6. Requested Duration:	
12 months	
Q7. Additional Information:	

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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
Prescriber Signature	Date

2023 Medicare Prior Authorization Request