Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Drizalma Sprinkle - 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 administration via nasogastric tube required or is there documentation that the patient has an inability to swallow an intact capsule?

☐ Yes ☐ No

Q2. Does the patient have a documented diagnosis of MDD with inadequate response, intolerance, or contraindication to one liquid antidepressant (e.g. fluoxetine liquid, citalopram solution, escitalopram solution, sertraline concentrate)?

☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of GAD with inadequate response, intolerance, or contraindication to one liquid antidepressant (e.g. escitalopram solution, paroxetine suspension)?

☐ Yes ☐ No

Q4. Does the patient have a documented diagnosis of DPNP or FM with inadequate response, intolerance, or contraindication to gabapentin solution?

☐ Yes ☐ No

Q5. Does the patient have a documented diagnosis of chronic musculoskeletal pain?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is the patient 7 years of age or older?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q8. Requested Duration: ☐ 12 months	
Q9. Additional Information:	

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request