Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

CGRP Antagonists - 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 the patient 18 years of age or older?

☐ Yes ☐ No

Q2. Does the patient have a confirmed diagnosis of migraines based on the most current criteria from the International Headache Society Classification of Headache Disorders?

☐ Yes ☐ No

Q3. Does the patient have a confirmed intolerance or inadequate response to a 4-week minimum trial with at least one preventive medication from two of the following classes: beta blockers, antidepressants, anticonvulsants)?

☐ Yes ☐ No

Q4. Does the patient have a confirmed diagnosis of episodic cluster headaches based on the most current criteria from the International Headache Society Classification of Headache Disorders?

☐ Yes ☐ No

Q5. Does the patient have a history of inadequate response, inability to tolerate or contraindication to at least one other preventative medication recommended by current consensus guidelines for episodic cluster headache?

☐ Yes ☐ No

Q6. Requested duration:

☐ 12 months

Q7. Additional Information:

Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

CGRP Antagonists - 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:**

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request