## Health Partners Medicare

## PRIOR AUTHORIZATION REQUEST FORM

Part B vs D: Inhalation Sol: Nebupent - 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:
.ine of Business: □ Medicare		NPI: State Lic ID:
Address:		Address:
City, State ZIP:		City, State ZIP:
Primary Phone:		Specialty/facility name (if applicable):
	<u>DITED REVIEW</u> : By checking this box and signing below, I enrollee or the enrollee's ability to regain maximum funct	certify that applying the 72 hour standard review timeframe may seriously jeopardize ion.
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 using the requested drug with a nebulizer?		
☐ Yes		□ No
Q2. Does the patient have a diagnosis of human immunodeficiency virus (HIV) (ICD-10 diagnosis code B20), or pneumocystosis (ICD-10 diagnosis code B59), or complications of organ transplants (ICD-10 diagnosis code T86.00-T86.03, T86.09-T86.13, T86.19-T86.23,T86.290,T86.298, T86.30-T86.33,T86.39-T86.43,T86.49,T86.5, T86.810-T86.812, T86.818, T86.819, T86.830-T86.832, T86.838, T86.839, T86.852, T86.858, T86.859, T86.890-T86.892, T86.898, T86.899, T86.90-T86.93, T86.99)?		
☐ Yes		□ No
Q3. Additional Information:		
Q4. Duration:		
☐ 12 Months		☐ Other
	Prescriber Signature	Date  2022 Medicare Prior Authorization Request
		2023 Medicare Prior Authorization Request

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