

PRIOR AUTHORIZATION REQUEST FORM

Part B vs D: Inhalation Sol-Tobramycin - 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 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 the life or health of the enrollee or the enrollee's ability to Drug Name: Strength: | | r standard review timeframe may seriously jeopardize | |
| Directions / SIG: | | | |
| | story including labs and information for th ase answer the following questions and silug with a nebulizer? | | |
| ☐ Yes | ☐ No | | |
| Q2. Does the patient have a diagnosis of J47.0, J47.1, J47.9, Q33.4)? | of cystic fibrosis or bronchiectasis (ICD-10 |) diagnosis codes A15.0, E84.0, | |
| Yes | ☐ No | | |
| Q3. Additional Information: | | | |
| Q4. Duration: | | | |
| ☐ 12 Months | ☐ Other | | |
| Prescriber Signature | | Date | |
| | 20 | D23 Medicare Prior Authorization Reques | |

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