Health Partners •••• Medicare

2023 PRIOR AUTHORIZATION REQUEST FORM

Orkambi - 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):
he life or health of the enrollee or the enrollee's ability	s box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize to regain maximum function.
Drug Name: Strength:	
Directions / SIG:	
	nistory including labs and information for this member that may support approval. ease answer the following questions and sign.
Q1. Is Orkambi being prescribed	by a pulmonologist, endocrinologist, or pediatrician?
☐ Yes	□ No
Q2. Does the patient have a con	firmed diagnosis of cystic fibrosis?
☐ Yes	□ No
	ting been conducted showing that the patient is homozygous for R gene? Please attached appropriate lab work.
☐ Yes	□ No
,	including alanine aminotransferase [ALT], aspartate ubin) been assessed prior to initiation of treatment (labs must be
☐ Yes	□ No
Q5. Additional Information:	
Properiher Signature	
Prescriber Signature	2023 Medicare Prior Authorization Request
	2020 Micalcule i noi Authorization Negaco

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