

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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**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.**

<p>Q1. Does the patient have a documented diagnosis of hereditary angioedema (HAE)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is the patient 6 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the prescriber an allergist or immunologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Additional Information:</p>
<p>Q6. Duration:</p> <p><input type="checkbox"/> 12 months</p>

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

2022 Medicare Prior Authorization Request