

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: <input type="checkbox"/> 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.**

<p>Q1. Is the patient 3 years of age and older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Does the patient have a diagnosis of chronic hepatitis C with supporting documentation?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the patient:</p> <p><input type="checkbox"/> Treatment-naïve <input type="checkbox"/> Treatment-experienced</p>
<p>Q4. Are the following baseline labs attached?</p> <p>A.) HCV genotype and subtype B.) Quantitative HCV RNA C.) Complete blood count (CBC) D.) International normalized ratio (INR) E.) Hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels) F.) Serum creatinine/calculated glomerular filtration rate G.) Transient elastography (such as FibroScan) or noninvasive serologic tests (such as FibroSure) H.) Hepatitis B surface antigen (HBsAg), Hepatitis B core antibody (anti-HBc), Hepatitis B surface antibody (anti-HBs) I.) HIV antigen/antibody test</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Does the patient have any conditions that would fall under the exclusion criteria per AASLD guidance?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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Patient Name:	Prescriber Name:
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Q6. Additional Information:

Q7. Duration:

8 weeks

12 weeks

24 weeks

Prescriber Signature

Date

2022 Medicare Prior Authorization Request