

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 requested medication being prescribed for a medically accepted indication not otherwise excluded from Part D?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Please provide the diagnosis:</p>
<p>Q3. Is the patient stable on the current medication or is there a high risk of significant adverse clinical outcome with a medication change? [Note: Please specify anticipated significant adverse clinical outcome.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is this a request for a non-formulary medication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Has the patient tried and failed, had an adverse outcome, or has a contraindication to all formulary alternatives? [Note: Please specify the drug(s) contraindicated or tried, adverse outcomes for each, and if a therapeutic failure, the length of therapy for each drug.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is this a request for a medication at a higher dosage than allowed by the plan?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Has the patient tried and failed the medication at a lower dosage and this dosage was not appropriate?</p>

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<p>[Note: Please specify the following: the outcome of the trial, the medical reason for higher dosage, why less frequent dosing with a higher strength would not be an option for the patient (if higher strength exists).]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q8. Is this a request for a medication in which the dosage form is non-formulary?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q9. Has the patient tried and failed the formulary dosage form? [Note: Please specify the dosage form tried, the result of the trial, and the medical reason why the non-formulary dosage form is necessary.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q10. Is this a request for a medication that interacts with or is a duplication of therapy with another medication that the patient is currently taking?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q11. Will the interacting or duplicative medication be discontinued?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q12. Is there documentation to show that the patient will be monitored while taking the interacting or duplicative medications?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q13. Is this a request for an early refill of a medication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q14. Has an early refill request for the same medication been made within the last 90 days?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q15. Will the patient be temporarily absent from the Commonwealth or the United States for an extended period of time that is greater than the remaining day supply of the earlier-dispensed medication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q16. Is this a request for a change in dosage of the medication or increased dosing frequency?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q17. Was the medication lost or stolen?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q18. Has documentation (such as a copy of a police report and full description of events with date and time of theft or loss, an insurance report, fire report, etc.) of the loss or theft been provided?</p>	

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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Additional Information	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Duration:	
<input type="checkbox"/> 12 months	

Prescriber Signature

Date

2022 Medicare Prior Authorization Request