

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. Is the medication being used for an FDA approved indication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is the patient 18 years or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is this medication being prescribed by or in consultation with an endocrinologist or parathyroid specialist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Does the patient have a documented risk of osteosarcoma (including Paget's disease or unexplained elevation of alkaline phosphatase, open epiphyses, hereditary disorders predisposed to osteosarcoma, or a history of external beam or implant radiation therapy)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Is there documentation showing uncontrolled hypocalcemia despite treatment with calcium supplements and active forms of vitamin D?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Are labs attached showing serum calcium is above 7.5 mg/dL and serum 25-hydroxyvitamin D level is within normal range prior to starting Natpara?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Will Natpara be used along with calcium supplementation or active forms of vitamin D?</p>

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>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Additional Information:	
Q9. Requested Duration: <input type="checkbox"/> 12 months	

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

\_\_\_\_\_  
Date

2022 Medicare Prior Authorization Request