

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 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Does the patient have a confirmed diagnosis of migraines based on the most current criteria from the International Headache Society Classification of Headache Disorders?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Does the patient have a confirmed intolerance or inadequate response to a 4 week minimum trial with at least one preventative medication from two of the following classes: beta blockers, antidepressants, anticonvulsants)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Does the patient have a confirmed diagnosis of episodic cluster headaches based on the most current criteria from the International Headache Society Classification of Headache Disorders?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Does the patient have a history of inadequate response, inability to tolerate or contraindication to at least one other preventative medication recommended by current consensus guidelines for episodic cluster headache ?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Additional Information:</p>
<p>Q7. Duration:</p> <p><input type="checkbox"/> 12 months</p>

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

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:
---------------	------------------

Prescriber Signature

Date

2022 Medicare Prior Authorization Request