

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 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 diagnosis of pain associated with post-herpetic neuralgia or diabetic peripheral neuropathy? Chart notes must be attached.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Has the patient had a documented inadequate response or inability to tolerate gabapentin and immediate release Lyrica?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is the prescribed dose for Lyrica CR within the package insert requirements (maximum of 330 mg per day for DPN, maximum of 660 mg per day for PHN)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Requested Duration:</p> <p><input type="checkbox"/> 12 Months <input type="checkbox"/> Other</p>
<p>Q6. Additional Information:</p>

Prescriber Signature

Date

---

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>
----------------------	-------------------------

2022 Medicare Prior Authorization Request