Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Copaxone® (glatiramer acetate) - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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 left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this member that may support approval. Please answer the following questions and sign.

Q1. What is the requested duration of therapy?

☐ 12 months or less

☐ Greater than 12 months

Q2. What is the patient's age?

☐ Less than 18 years

☐ Equal to or greater than 18 years

Q3. Is the prescriber a neurologist?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of relapsing forms of multiple sclerosis (RRMS)?

☐ Yes ☐ No

Q5. Has the patient experienced a first clinical episode and have MRI features consistent with multiple sclerosis?

☐ Yes ☐ No

Q6. Additional Information / Comments

Q7. Deliver to:

☐ Physician's Office ☐ Home Delivery

Q8. Delivery date needed:

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Prescriber Signature	Date