Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Botox® (Botulinum Toxin Type A) Renewal

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 treatment?

☐ One injection

☐ More than one injection

Q2. Has the prescriber provided medical documentation to support the need for repeat treatment also showing previous injection sites and any proposed sites for repeat treatment occuring no sooner than 3 months? Documentation must be attached.

☐ Yes ☐ No

Q3. Comments:

Q4. Additional Information / Comments:

Q5. Deliver to:

☐ Physician's Office ☐ Home Delivery

Q6. Delivery date needed:

Prescriber Signature

Date