

## HEALTH PARTNERS MEDICARE PRIOR AUTHORIZATION REQUEST FORM

## Health Partners Plans

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

Botox® (Botulinum Toxin Type A) Renewal

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 reques	ted duration of treatment?	
□ One injection		
$\Box$ More than one inject	tion	
•	provided medical documentation to support the need for repeat treatment also showing previous proposed sites for repeat treatment occuring no sooner than 3 months? Documentation must be	
□ Yes		
Q3. Comments:		
Q4. Additional Informat	ion / Comments:	
Q5. Deliver to:		
□ Physician's Office	Home Delivery	
Q6. Delivery date need	ed:	

Prescriber Signature

Date

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