Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

High Risk Medications 1st Generation Antihistamine

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 (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: □ 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.

Q1. Is this High Risk Medication being used for a FDA approved indication?

☐ Yes ☐ No

Q2. What is the patient's diagnosis? Please provide chart notes documenting diagnosis.

Q3. Is the patient 65 years of age or older?

☐ Yes ☐ No

Q4. Has a risk-versus-benefit assessment been completed for the High Risk Medication? Please provide assessment and a detailed explanation of the specific benefit established and how the benefit outweighs the potential risk.

☐ Yes ☐ No

Q5. Has the patient been counseled on the potential side effects and risks of the requested High Risk Medication? Must provide documentation of patient counseling.

☐ Yes ☐ No

Q6. For allergic conditions, has the patient had an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as levocetirizine, desloratadine, azelastine nasal spray, fluticasone propionate nasal spray or mometasone nasal spray?

☐ Yes ☐ No ☐ Not Applicable

Q7. Duration:

☐ 12 months

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Patient Name:	**Prescriber Name:**

Q8. Additional Information:

Q9. For CMS Reporting, where does the patient reside?

- ☐ 00 - Not specified, other patient residence not identified below
- ☐ 01 - Home
- ☐ 03 - Nursing Facility
- ☐ 04 - Assisted Living Facility
- ☐ 06 - Group Home
- ☐ 09 - Intermediate Care Facility/Mentally Retarded
- ☐ 11 - Hospice

Prescriber Signature

Date

2019 Medicare Prior Authorization Request