



HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Forteo - 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with two columns: Patient Name and Prescriber Name. Fields include Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, State Lic ID, Address, City, State ZIP, and Specialty/facility name.

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. Does the patient have a documented diagnosis of osteoporosis (glucocorticoid-induced, primary or hypogonadal in men, glucocorticoid-induced or postmenopausal in women)? Please submit documentation.

Yes No

Q2. Is the patient 18 years of age or older?

Yes No

Q3. Is the prescriber an appropriate specialist or in consultation with an appropriate specialist such as an endocrinologist?

Yes No

Q4. Are the following baseline labs [DXA scan, serum calcium, phosphorus, creatinine, alkaline phosphatase, albumin, and 25-hydroxy vitamin D (25[OH]D)] attached?

Yes No

Q5. Has the patient had an inadequate response or the inability to tolerate at least one of the following: A) bisphosphonates, B) hormone replacement therapy, C) selective-estrogen receptor modulators (SERMs)?

Yes No

Q6. Additional Information:

Q7. Requested Duration:

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party.



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Patient Name:

Prescriber Name:

12 Months

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

2021 Medicare Prior Authorization Request