Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

High Risk Meds - 1st Gen Antihistamine - 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.

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 the patient 65 years of age or older?

[Note: The Prior Authorization requirement only applies to patients 65 years of age or older. Prior Authorization is not required for patients under 65 years of age.]

☐ Yes ☐ No

Q2. Is this High Risk Medication being used for a medically accepted indication?

☐ Yes ☐ No

Q3. Please list indication for use AND include chart notes documenting the patient's diagnosis:

Q4. Has a risk-versus-benefit assessment been completed for the High Risk Medication?
[Note: Please provide an 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?
[Note: Please provide documentation of patient counseling.]

☐ Yes ☐ No

Q6. Is the requested drug being prescribed for the treatment of allergic conditions?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q7. Does the patient have chart notes documenting 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?
[Note: Chart notes must be attached.]

☐ Yes ☐ No

Q8. Additional Information:

Q9. Requested Duration:

☐ 12 months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request