Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

High Risk-Non-Benzo Sedative Hypnotics - 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 this High Risk Medication being used for a medically accepted indication?

☐ Yes ☐ No

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

☐ Yes ☐ No

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?
Please provide documentation of patient counseling.

☐ Yes ☐ No

Q6. Has the patient had an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as temazepam, ramelteon, or doxepin (generic Silenor)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q7. Additional Information:

Q8. Requested Duration:

☐ 12 months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request