



HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Ingrezza - 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.

Seven question blocks (Q1-Q7) regarding therapy continuation, previous approvals, symptom improvement, age, consultation with specialists, diagnosis, and exclusion of other movement disorders.

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Patient Name:

Prescriber Name:

Q8. Does the patient have documentation of current or former chronic use of a dopamine antagonist (e.g., antipsychotic [first or second generation], metoclopramide, prochlorperazine, droperidol, promethazine)? Please attach documentation.

Yes checkbox

No checkbox

Q9. Have all potential contraindications (including congenital long QT syndrome, arrhythmias associated with prolonged QT interval, severe renal impairment, pregnancy) been excluded?

Yes checkbox

No checkbox

Q10. Will Ingrezza be used concurrently with either a monoamine oxidase (MAO) inhibitor or strong cytochrome 3A4 (CYP3A4) inducer?

Yes checkbox

No checkbox

Q11. Additional Information:

Q12. Requested Duration:

12 Months checkbox

Prescriber Signature

Date

2021 Medicare Prior Authorization Request