



HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Targretin Gel - 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. Will Targretin gel be prescribed by a dermatologist, hematologist, or oncologist?

Yes No

Q2. Is the requested medication being used for a medically-accepted indication not otherwise excluded from Part D? Please provide documentation of diagnosis.

Yes No

Q3. Additional Information:

Q4. Duration:

12 months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request