



**HEALTH PARTNERS MEDICARE  
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

Topical Retinoids - 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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member Number:	Fax: <span style="float: right;">Phone:</span>
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Medicare	NPI: <span style="float: right;">State Lic ID:</span>
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 requested medication being used for a medically-accepted indication not otherwise excluded from Part D?  
 Yes  No

Q2. Please list indication for use AND include chart notes documenting the patient's diagnosis:

Q3. Additional Information:

Q4. Duration:  
 12 months

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

\_\_\_\_\_  
Date

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