

## HEALTH PARTNERS MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Actimmune - 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 the life or health of the enrollee or the enrollee's ability to regain maximum funct  Drug Name:  Strength:  Directions / SIG:		ur standard review timeframe may seriously jeopardize
Please attach any pertinent medical history including lab	s and information for the	
Q1. Is the requested medication being used for a medical		
☐ Yes	□ No	
Q2. Has documentation of the diagnosis been provided?		
Yes	☐ No	
Q3. Additional Information:		
Q4. Requested Duration:		
☐ 12 Months		
Prescriber Signature		Date

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