



HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Ambrisentan - 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) with checkboxes for Yes/No. Questions cover prescriber specialty, patient age, gender, pregnancy status, and contraceptive use.

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Patient Name:

Prescriber Name:

Q8. Does the patient have a contraindication such as idiopathic pulmonary fibrosis?

Yes

No

Q9. Does the patient have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?

Yes

No

Q10. Has the diagnosis of pulmonary arterial hypertension (PAH) been confirmed by a complete right heart catheterization (RHC)? If Yes, please attach documentation.

PAH is defined as:

A) A mean pulmonary arterial pressure (mPAP) greater than 20 mmHg

B) A pulmonary capillary wedge pressure/ left ventricular end-diastolic pressure (PCWP/LVEDP) less than or equal to 15 mmHg

C) A pulmonary vascular resistance (PVR) greater than 3 Wood units

Yes

No

Q11. Will the patient's hemoglobin and hematocrit levels be monitored periodically (baseline, at 1 month, and periodically thereafter)?

Yes

No

Q12. Additional Information:

Q13. Requested Duration:

12 Months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request