HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Part B vs D: Oral Antiemetic Agents - 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 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 drug being used as part of a cancer chemotherapy regimen?

☐ Yes ☐ No

Q2. Will the oral antiemetic formulation be used as a full therapeutic replacement for intravenous administration of an antiemetic within 48 hours of chemotherapy?

☐ Yes ☐ No

Q3. Will this drug be part of a regimen that includes an oral corticosteroid (e.g., dexamethasone) and an oral 5-HT3-receptor antagonist (e.g., ondansetron, granisetron, Anzemet)?

☐ Yes ☐ No

Q4. Is the patient receiving one or more of the following chemotherapeutic agents: Azacitidine, Bendamustine, Carboplatin, Carmustine, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Daunorubicin, Doxorubicin, Epirubicin, Idarubicin, Ifosfamide, Irinotecan, Lomustine, Oxaliplatin, Streptozocin?

☐ Yes ☐ No

Q5. Additional Information:

Q6. Requested Duration:

☐ 12 Months

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Part B vs D: Oral Antiemetic Agents - 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:**

Prescriber Signature   Date

2021 Medicare Prior Authorization Request

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document