Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Mavenclad - 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 patient 18 years of age or older?

☐ Yes ☐ No

Q2. Does the patient have a confirmed diagnosis of multiple sclerosis including relapsing-remitting or active secondary progressive disease?

☐ Yes ☐ No

Q3. Is the requested drug being prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q4. Does the patient have any contraindications to the requested drug? Contraindications include but not limited to: Current malignancy, pregnancy, active infection (HIV, hepatitis, TB), hypersensitivity to cladribine, clinically isolated syndrome, any contraindications listed in the FDA-approved prescribing information, female patients intending to breastfeed on a treatment day and for 10 days after the last dose.

☐ Yes ☐ No

Q5. Is the patient of reproductive potential?

☐ Yes ☐ No

Q6. Will the patient use effective contraception during treatment with Mavenclad and for 6 months after last dose?

☐ Yes ☐ No

Q7. Will the patient be treated with more than 2 treatment courses exceeding 2 years of treatment?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q8. Has documentation of the patient having trial and failure or intolerance to at least one alternative drug included?	
☐ Yes	☐ No
Q9. Additional Information:	
Q10. Duration:	
☐ 12 months	

Prescriber Signature

Date

2021 Medicare Prior Authorization Request