

## HEALTH PARTNERS MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Cinryze - 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.

| Phone:        |
|---------------|
|               |
| State Lic ID: |
|               |
|               |
| ble):         |
|               |

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. Does the patient have a documented diagnosis of hereditary angioedema (HAE)?                                      |        |  |
|   | □ No   |  |
| Q2. Is the patient 6 years of age or older?   |        |  |
|   | □ No   |  |
| Q3. Is the prescriber an allergist or immunology  | ogist? |  |
|   | □ No   |  |
| Q4. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D?         |        |  |
| ☐ Yes   | □ No   |  |
| Q5. Additional Information:   |        |  |
| Q6. Duration:   |        |  |
| 12 months   |        |  |
|   |        |  |

**Prescriber Signature** 

Date

2021 Medicare Prior Authorization Request

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