Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Xpovio - 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. Does the patient have a documented diagnosis of relapsed or refractory multiple myeloma?
☐ Yes ☐ No

Q2. Does the patient have a documented diagnosis of relapsed or refractory diffuse large B-cell lymphoma?
☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of multiple myeloma?
☐ Yes ☐ No

Q4. Is the medication being used for a medically accepted indication?
☐ Yes ☐ No

Q5. Is there documentation showing previous treatment with at least four prior therapies, including two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody?
☐ Yes ☐ No

Q6. Is there documentation of previous treatment with at least 2 lines of systemic therapy?
☐ Yes ☐ No

Q7. Is there documentation of previous treatment with at least one prior therapy?
☐ Yes ☐ No

Q8. Is the medication being prescribed by or in consultation with an oncologist or hematologist?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q9. Is the patient 18 years of age or older?	
☐ Yes	☐ No
Q10. Additional Information:	
Q11. Requested Duration:	
☐ 12 months	

Prescriber Signature

Date

2021 Medicare Prior Authorization Request