Health Partners •••• Medicare

PRIOR AUTHORIZATION REQUEST FORM

Ztalmy - 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.

atient Name:	Prescriber Name:
lember Number:	Fax: Phone:
Date of Birth:	Office Contact:
.ine of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):
he life or health of the enrollee or the enrollee's ability to Drug Name:	regain maximum function.
Strength:	
Directions / SIG:	
Please attach any pertinent medical his	story including labs and information for this member that may support approval.
Plea	se answer the following questions and sign.
Q1. Does the patient have a documented (CDD)?	d diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder
☐ Yes	□ No
Q2. Is Ztalmy being prescribed by or in o	consultation with a neurologist?
☐ Yes	□ No
Q3. Additional Information:	
Prescriber Signature	 Date
	2023 Medicare Prior Authorization Reques

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