PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Non-formulary drug

HEALTH PARTNERS
In Wellness and Health, Partners for Life.

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS 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 print clearly.**

Patient Name:	**Physician Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the requested duration of therapy?
Q2. What is the patient's diagnosis?
Q3. Has the patient previously received this medication? Yes No
Q4. If yes, how long has the patient been treated with this medication?
Q5. List all medications patient has been treated with previously that have resulted in failure or patient intolerance (for each please state the adverse outcome or type of failure).
Q6. Rationale for use of this non-formulary medication (include or attach relevant lab or diagnostic test results).

Physician Signature **Date**