

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Antivirals - Influenza

Phone: 215-991-4300

Fax back to: 866-240-3712

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.

Member Name:		Prescriber Name:	
HPP Member Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Member Primary Phone:		NPI:	PA PROMISe ID:
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Line of Business: Medicaid CHIP		Specialty Pharmacy (if applicable):	
Drug Name:		Strength:	
Quantity:		Refills:	
Directions:			
Diagnosis Code:	Diagnosis:		
HPP's maximum appro	val time is 12 m	onths but may be less dependin	g on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.		
	e a documented history of therapeutic failure, contraindication to, or ed influenza antiviral drugs (e.g., oseltamivir, Relenza)?	
□ Yes	□ No	
Q2. Additional Information	ר:	

Prescriber Signature

Date

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