Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Marinol®

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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending 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.

Q1. Does the patient have a diagnosis of HIV/AIDS?
☐ Yes ☐ No

Q2. Is a nutritional consult documenting poor appetite and insufficient caloric intake provided?
☐ Yes ☐ No

Q3. Does the patient have a diagnosis of chemotherapy-induced nausea and vomiting?
☐ Yes ☐ No

Q4. Has the patient tried and failed ondansetron?
☐ Yes ☐ No

Q5. Requested Duration:
☐ 3 Months

Q6. Additional Information:

Prescriber Signature

Date

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