



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

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

Expedited/Urgent checkbox

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 checkbox

No checkbox

Q2. Is a nutritional consult documenting poor appetite and insufficient caloric intake provided?

Yes checkbox

No checkbox

Q3. Does the patient have a diagnosis of chemotherapy-induced nausea and vomiting?

Yes checkbox

No checkbox

Q4. Has the patient tried and failed ondansetron?

Yes checkbox

No checkbox

Q5. Requested Duration:

3 Months checkbox

Q6. Additional Information:

Prescriber Signature

Date

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Prescriber Name:

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