Health Partners Plans

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Otic Antibiotics

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 note any information left blank or illegible may delay the review process.**

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

Drug Name:	Expedited/Urgent
Directions:	
Patient belongs to (please check one): HEALTH PARTNERS	KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:

Q1. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred otic antibiotics approved or medically accepted for the patient's diagnosis?

Yes No

Q2. Additional Information:

Physician Signature **Date**