



Pharmacy Administration - Prior Authorization / Exception Form

Prescriber: Please complete *Patient*, *Provider* and *Requested Therapy* sections.

For questions please call 952-883-5813 or 800-492-7259. Incomplete submissions will be returned and may delay review.

FAX to 952-853-8700 or 1-888-883-5434

Patient	Last Name		First	MI
	Date of Birth		HealthPartners Insurance ID #	
	Patient Address			
Provider	Today's Date		Clinic Name	
	Provider Name (FIRST and LAST)		Clinic Address	
	Specialty		Telephone #	
	Contact Person		Fax #	
	Federal Tax ID (only needed for medications given in-clinic)		Recommended by Consultant? <input type="checkbox"/> Yes <input type="checkbox"/> No Name Specialty	
Requested Therapy	Drug Requested		Dose Schedule	Duration of Therapy Desired
	Diagnosis/Clinical Information			
	Previous Therapies & Outcomes			

HealthPartners Preferred Drug List (Formulary), Prior Approval and Medical Coverage Criteria are available at www.healthpartners.com

HealthPartners Review Determination	
<input type="checkbox"/> APPROVED <i>Please notify patient and pharmacy.</i>	<input type="checkbox"/> DENIED per Medical Director review
<input type="checkbox"/> Note from HealthPartners	

Group / Pkg / FI or SI / PCR Plan	For Internal Use	PCSA / Date	RPh / Date
Open Closed NP TOC Pt Alert TE			

Confidentiality Notice: The information in this facsimile is confidential and intended for the use of the fax number shown above. If you are neither the intended recipient nor the employer or agent responsible for delivering this message to the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance of the contents of this communication is strictly prohibited. If you have received this facsimile in error, please immediately notify us by telephone at 952-883-5813 or 800-492-7259 to arrange for its return. Thank you for your assistance.