



**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**

<b>Patient</b>	Last Name		First	MI
	Date of Birth		HealthPartners Insurance ID #	
	Patient Address			
<b>Provider</b>	Today's Date		Clinic Name	
	Provider Name (FIRST and LAST)		Clinic Address	
	Specialty		Telephone #	
	Contact Person		Fax #	
	Federal Tax ID ( <i>only needed for medications given in-clinic</i> )		Recommended by Consultant? <input type="checkbox"/> Yes <input type="checkbox"/> No Name Specialty	
<b>Requested Therapy</b>	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](http://www.healthpartners.com)*

HealthPartners Review Determination	
<input type="checkbox"/> <b>APPROVED</b> <i>Please notify patient and pharmacy.</i>	<input type="checkbox"/> <b>DENIED</b> per Medical Director review <i>Denial letter has been mailed to the member.                  See attached copy for criteria and appeal rights.</i>
<input type="checkbox"/> <b>Note from HealthPartners</b>	

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

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*Last updated 01/07/08*