



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Marinol®

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 print clearly.**

Patient Name:	Physician Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic. Id:
Address:	Address:
City, State, Zip:	City, State, Zip:

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the requested duration of therapy? 6 months or less More than 6 months
Q2. Does the patient have a diagnosis of HIV/AIDS or cancer? Yes No
Q3. Have you attached a nutritional consult documenting poor appetite and insufficient caloric intake? Yes No

Physician Signature

Date