

Medicare Advantage Drugs/Biologics Part B Prior Authorization Form



This form applies to all HealthSpring Medicare markets. It does not apply to Medicaid only and Medicare-Medicaid Plans (MMP). Please fax to **877-730-3858** | Phone: **888-454-0013**

To ensure your request is processed in a timely manner, please submit all pertinent clinical information.

<input type="checkbox"/> Expedited - defined as danger to a member's health if not provided within 24 hours		
Member name	Member date of birth	
Requesting provider	Member ID	
Contact person	Date of service	
Address		
NPI	Phone	Fax

If referring to a servicing provider, the information below must be submitted.

Servicing provider	Phone
Contact person	Fax
Address	
<input type="checkbox"/> Check here if servicing provider is out of network. Please explain.	

<input type="checkbox"/> New authorization request	<input type="checkbox"/> Extension of existing authorization. For extension of existing authorization, please submit authorization number _____
Who will supply the medication?	Please select place of service by checking only one of the boxes
<input type="checkbox"/> Provider office	<input type="checkbox"/> Provider office
<input type="checkbox"/> Outpatient hospital/clinic	<input type="checkbox"/> Outpatient hospital/clinic
<input type="checkbox"/> Pharmacy not located within the servicing facility	<input type="checkbox"/> Other. Please specify _____
Diagnosis codes	Diagnosis

Please attach all required documentation: recent clinical notes, copy of the prescription or provider order, relevant diagnostic lab results and relevant radiology notes.

All chemotherapy orders must indicate the number of cycles requested _____ cycles

HCPCS codes	Drug (if applicable)	Dose (if applicable)	Frequency	Duration

If requesting more than 10 HCPCS codes, please attach an additional form.