



**Medicare Advantage-Prescription Drug Plan
Prior Approvals Request Form**
Incomplete Form May Delay Processing

PHYSICIAN NAME		PATIENT NAME	
OFFICE CONTACT PERSON		PATIENT ID #	
PHYSICIAN PHONE	PHYSICIAN FAX	PATIENT DATE OF BIRTH	
PHYSICIAN ADDRESS			
Street		City	State Zip

Name of Medication requested: _____

Dosage Form of Medication requested: _____
(injectable, pill/capsule/tablet, suppository, liquid, etc.)

Part D coverage of certain drugs is available only if coverage is not available under PART B.
(please see the DMERC website <http://palmettogba.com> for PART B coverage clarification)

Clinical Reasons drug covered under PART D drug benefit: _____

I certify that the member meets criteria for PART D coverage of this drug.

Physician Signature: _____

Please Return Completed Form To:
Fax number: 1-888-446-8535
Address: PARTNERS
Attention: Exceptions-Health Services
P.O. Box 17509
Winston-Salem, NC 27116-7509
Provider telephone: 1-888-296-9790