



**PRIOR AUTHORIZATION REQUEST FORM**

EOC ID:

**Genotropin (somatropin)**

**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:**

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

**Physician Name:**

Fax:

Phone:

Office Contact:

NPI:

State Lic. Id:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

**Please answer the following questions and sign below:**

Q1. What is the prescriber's specialty?

Endocrinologist      Other

Q2. Is the patient compliant with therapy?

Yes      No

Q3. Has the patient had significant side effects (such as leukemia, antibody production)?

Yes      No

Q4. Deliver to:

Physician's Office      Home Delivery

Q5. Delivery date needed:

**Physician Signature**

**Date**

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