PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Leuprolide for Men

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 intent of the treatment? Palliative treatment of advanced prostate cancer. Other
Q2. If Other, Please specify:
Q3. Will periodic monitoring of serum testosterone and PSA levels been performed during therapy? Yes No
Q4. Deliver to: Physician's Office Home Delivery
Q5. Delivery date needed:

Physician Signature

Date

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