



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Lupron Depot - Pediatric

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:
<p>Q1. What is the patient's diagnosis:</p> <p>Idiopathic Central Precocious Puberty</p> <p>Neurogenic Central Precocious Puberty</p> <p>Other</p>
<p>Q2. If Other, Please specify:</p>
<p>Q3. Is the patient a female less than 8 years of age or a male less than 9 years of age?</p> <p>Yes No</p>
<p>Q4. Has the diagnosis been confirmed by a pubertal response to a GnRH stimulation test?</p> <p>Yes No</p>
<p>Q5. Has a baseline evaluation been performed including height, weight, height velocity and skeletal age; TSH level; sex steroid level; adrenal steroid level; beta human chorionic gonadotropin level; pelvic/adrenal/testicular ultrasound; brain imaging of the head to rule out intracranial tumor?</p> <p>Yes No</p>
<p>Q6. Deliver to:</p> <p>Physician's Office Home Delivery</p>
<p>Q7. Delivery date needed:</p>

Physician Signature

Date