



**PRIOR AUTHORIZATION REQUEST FORM**

EOC ID:

Megace®

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 requested duration of therapy?  
6 months or less      More than 6 months

Q2. Does the patient have a diagnosis of HIV/AIDS or cancer?  
Yes      No

Q3. Have you attached a nutritional consult documenting poor appetite and insufficient caloric intake?  
Yes      No

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**