PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Norditropin (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:	**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 prescriber's specialty? Endocrinologist Other
Q2. If Other, please specify:
Q3. Is the patient compliant with the therapy? Yes No
Q4. Has the patient experienced any significant side effects (such as leukemia, antibody production)? Yes No
Q5. Deliver to: Physician's Office Home Delivery
Q6. Delivery date needed:

Physician Signature **Date**

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