



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Zoladex (goserelin)

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. Which product is being requested? Zoladex 3.6mg (1-month implant) Zoladex 10.8mg (3-month implant)
Q2. What is the requested duration of therapy? Twelve (12) months or less More than 12 months
Q3. What is the intent of the treatment? Palliative treatment of advance carcinoma of the prostate Locally confined stage T2b-T4 (stage B2-C) carcinoma of the prostate Management of endometriosis Palliative treatment of advance breast cancer in pre- and perimenopausal women Endometrial-thinning agent prior to endometrial ablation for dysfunctional uterine bleeding Other
Q4. What is the patient's gender? Male Female
Q5. If female, is there known or suspected pregnancy, or is the patient currently lactating? Yes No
Q6. If female, is there currently abnormal vaginal bleeding of unknown etiology? Yes No
Q7. For endometrial ablation, is the use of Danazol as an alternative NOT considered an option? Yes No
Q8. If Endometriosis, has the patient failed an adequate treatment course with oral contraceptives or depot medroxyprogesterone acetate? Yes No
Q9. Deliver to:



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Patient Name:

Physician Name:

Physician's Office Home Delivery

Q10. Delivery date needed:

Physician Signature

Date

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