



**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.**

<b>Patient Name:</b>	<b>Physician Name:</b>
Member Number:	Fax: <span style="float: right;">Phone:</span>
Date of Birth:	Office Contact:
Group Number:	NPI: <span style="float: right;">State Lic. Id:</span>
Address:	Address:
City, State, Zip:	City, State, Zip:

Drug Name: Expedited/Urgent

Directions:

<b>Please answer the following questions and sign below:</b>
<p>Q1. Which product is being requested?          Zoladex 3.6mg (1-month implant)          Zoladex 10.8mg (3-month implant)</p>
<p>Q2. What is the requested duration of therapy?          Twelve (12) months or less          More than 12 months</p>
<p>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</p>
<p>Q4. What is the patient's gender?          Male      Female</p>
<p>Q5. If female, is there known or suspected pregnancy, or is the patient currently lactating?          Yes      No</p>
<p>Q6. If female, is there currently abnormal vaginal bleeding of unknown etiology?          Yes      No</p>
<p>Q7. For endometrial ablation, is the use of Danazol as an alternative NOT considered an option?          Yes      No</p>
<p>Q8. If Endometriosis, has the patient failed an adequate treatment course with oral contraceptives or depot medroxyprogesterone acetate?          Yes      No</p>
<p>Q9. Deliver to:</p>



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**Patient Name:**

**Physician Name:**

Physician's Office

Home Delivery

Q10. Delivery date needed:

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

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

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