

**Physician's Prior Authorization Questionnaire  
Femara®**

**Patient:**

**ID#:**

**DOB:**

**Patient Address:**

Femara® is only covered for certain medical conditions. Please complete the following to assist us in making a determination of this patient's eligibility for coverage under his managed pharmacy benefits.

1. What is the patient's diagnosis? *(Please do not use codes.)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate if:

*Early*  Yes

*Locally Advanced*  Yes

*Metastatic*  Yes

2. Is this first line therapy?  Yes  No

3. Please indicate receptor status: \_\_\_\_\_  
\_\_\_\_\_

4. Is the patient postmenopausal?  Yes  No

5. How long do you anticipate this patient being prescribed this medication?  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please **Print** Physician's Name & Specialty

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at [www.usableadmin.com/providers/PharmacyForms.aspx](http://www.usableadmin.com/providers/PharmacyForms.aspx)