

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

Patient:

ID#:

DOB:

Patient Address:

Iressa® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

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

2. Has the patient failed any prior chemotherapy regimen(s)? Yes No

If Yes, please list the regimen(s): _____

3. Is the patient currently taking Iressa®? Yes No

4. Has the patient taken Irressa® prior to this request? Yes No

5. Will other forms of chemotherapy be used while on Iressa®? Yes No

If Yes, please list the regimen(s): _____

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