

**Physician's Prior Authorization Questionnaire  
Megace ES®**

**Patient:**

**ID#:**

**DOB:**

**Patient Address:**

*Megace ES® oral suspension (625mg/5ml; 5ml per day dose) has a different dosing schedule from Megace® and other generic megestrol oral suspensions (800mg/20ml; 20ml/day dose) due to different strengths.*

Megace ES® 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. Patient's weight: \_\_\_\_\_
3. Patient's height: \_\_\_\_\_
4. Reason for use of megestrol: \_\_\_\_\_
5. What prior treatment to prevent weight loss has been attempted? \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
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)*