**Drug Requested:**

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
</table>

**Strength:**

**Frequency:**

**Qty Dispensed:**

**Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.**

- **New Medication**
- **Ongoing Medication**

**If Ongoing Provide Date Started:**

**If medication is ongoing, did the member show improvement while on therapy?**

**Will the drug be:**

- Billed directly by the provider via JCODE
- Billed by a pharmacy and delivered to the provider
- Billed by a pharmacy and delivered to the patient

**Please indicate place of administration:**

- Physician’s Office
- Hospital/Clinic
- Patient Home

**Please provide hospital/facility name and address:**

**Please indicate the diagnosis on the left and complete the corresponding questions.**

- **Prostate Cancer**
- **Breast Cancer**

- **Endometriosis**
  - What is the severity of the Endometriosis?
  - Has the diagnosis been confirmed by laparoscopy?
  - If NO, please provide chart documentation of an adequate work-up and the clinical rationale for the diagnosis.
  - Has the member tried oral contraceptives?

- **Central precocious puberty**
  - What age did the patient have an onset of secondary sexual characteristics?

- **Dysfunctional Uterine Bleeding**
  - Is the member undergoing endometrial ablation?

- **Uterine Leiomyomata or fibroids**
  - Does the member have anemia (Hemoglobin less than 11.)?
  - Is the medication being used as a preoperative adjuvant to surgery?

**HISTORY OF PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE CONDITION**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Date of</th>
<th>Strength</th>
<th>Frequency</th>
<th>List adverse reactions/side effects</th>
</tr>
</thead>
</table>

**Please provide any additional information which should be considered in the space below:**