

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber Name:	Member Name:		
Prescriber Specialty:	Identification #:		
Office Contact Name:	Group #:		
Group Name:	Date of Birth:		
Fax #:	Medication Allergies:		
Phone #:			
III. DRUG INFORMATION (One drug request per form)			
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:	
IV. REQUIRED DOCUMENTATION (Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)			
Specify diagnosis & diagnosis code relevant to this request:		Dx/Dx Code: _____	
Does the member have a history of contraindication to the prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>	
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Androgenic Agents? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.</i>	
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information: _____			
Therapeutic Duplication: If concurrently prescribed a therapeutic duplicate (i.e. another Androgenic Agent or dose different from the agent being requested): <ul style="list-style-type: none"> <input type="checkbox"/> is being transitioned from one Androgenic Agent to another with the intent of discontinuing one of the medications <input type="checkbox"/> has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines 			
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.			
HYPOGONADISM: <input type="checkbox"/> Has clinical and laboratory findings (such as testosterone, luteinizing hormone (LH), follicle-stimulating hormone (FSH)) supporting the diagnosis: _____			
GENDER DYSPHORIA: <input type="checkbox"/> If not prescribed by an endocrinologist please indicate a specialist consulted or if provider has training and/or experience in transgender medicine: _____ <input type="checkbox"/> Requested medication is prescribed in a manner consistent with the current World Professional Association for Transgender Health standards of care for the health of transsexual, transgender, and gender nonconforming people			
RENEWAL REQUESTS: <input type="checkbox"/> Member has experienced a positive clinical response as evidenced by: _____			

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

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Appropriate clinical information to support the request on the basis of medical necessity must be submitted.

Provider Signature:

Date:

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)