ESTROGENS PRIOR AUTHORIZATION FORM *(form effective 7/6/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/
Prior authorization guidelines for **Estrogens** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

Drug requested:	Strength/concentration:	
Dosage form:	Package size:	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.

1. For a non-preferred SYSTEMIC Estrogen:
☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred SYSTEMIC Estrogens (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

2. For a non-preferred VAGINAL Estrogen:
☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred VAGINAL Estrogens (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

3. For a diagnosis of GENDER DYSPHORIA:
☐The prescriber is an endocrinologist or medical provider with experience or training in transgender medicine
☐The drug is prescribed in a manner consistent with current WPATH standards of care

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**: