Prior Authorization Request Form for Androgenic Agents

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/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact 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 DOCUMENTION *(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?	☐ Yes ☐ No
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.*	☐ Yes Medications taken (start and end date and dose): _____ ☐ No

☐)Æ ÒÅÑÕÅÓÔÉÎÇ ÆÏÒ ÄÁÉÌÙ ÑÕÁÎÔÉÔÙ ÅØÃÅÅÄÉÎÇ ÄÁÉÌÙ ÌÉ Í ÉÔ ¡2Å£ÅÒ ÔÏ ÈÔÔÐÓ¢ŦŦ× × ×ßÄÈÓßÐÁßÇÏÖŦÐÒÏÖÉÄÅÒÓŦ0ÈÁÒ Í ÁÃÙ¢ 3ÁÒÖÉÅÅÁÓŦ0ÁÇÅÁŦ1ÕÁÎÔÉÔÙ¢,É Í ÉÔÓ¢ÁÎÄ$ÁÉÌÙ¢$ÏÓÅ¢,É Í ÉÔÓßÁÓÐØ¢ÐÌÁÁÓÅ ÐÒÏÖÉÄÅ ÓÕÐÐÏÒŦÎÇ ÉÎÆÏÒ Í ÁÔÉÏÎ¢.....

Therapeutic Duplication:
If concurrently prescribed a therapeutic duplicate (i.e. another Androgenic Agent or dose different from the agent being requested):

- ☐ is being transitioned from one Androgenic Agent to another with the intent of discontinuing one of the medications
- ☐ has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelinesß 3ÏÕÒÃÅ ÏÆ ÓÕÐÐÏÒŦÎÇ ÅÖÉÄÅÎÃÅ¢[ ]

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

HYPOGONADISM:

- ☐ Has clinical and laboratory findings (such as testosterone, luteinizing hormone (LH), follicle-stimulating hormone (FSH)) supporting the diagnosis:_____

GENDER DYSPHORIA:

- ☐ If not prescribed by an endocrinologist please indicate a specialist consulted or if provider has training and/or experience in transgender medicine:_____
- ☐ 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:

- ☐ Member has experienced a positive clinical response as evidenced by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :		
Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department 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.)