

## ANDROGENIC AGENTS PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Androgenic Agents** and **Quantity Limits/Daily Dose Limits**, accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	PA# _____				
Name of office contact: _____			Specialty: _____		
Contact's phone number: _____			State license #: _____		
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____		
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____		Suite #: _____	City/state/zip: _____		
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

### CLINICAL INFORMATION

<b>Preferred medication requested</b> (clinical prior authorization required):	<input type="checkbox"/> Androgel 1% gel pump	<input type="checkbox"/> Androgel 1.62% gel pump	<input type="checkbox"/> oxandrolone tablet	
	<input type="checkbox"/> Androgel 1% gel 2.5 gm packet	<input type="checkbox"/> Androgel 1.62% gel 1.25 gm packet	<input type="checkbox"/> testosterone cypionate injection	
	<input type="checkbox"/> Androgel 1% gel 5 gm packet	<input type="checkbox"/> Androgel 1.62% gel 2.5 gm packet		
<b>Non-preferred medication requested:</b>	<input type="checkbox"/> Anadrol-50 tablet	<input type="checkbox"/> Methitest tablet	<input type="checkbox"/> testosterone 1% gel 2.5 gm packet	
	<input type="checkbox"/> Androderm patch	<input type="checkbox"/> Natesto nasal gel	<input type="checkbox"/> testosterone 1% gel 5 gm packet	
	<input type="checkbox"/> Android capsule	<input type="checkbox"/> Striant tablet	<input type="checkbox"/> testosterone 1% gel 5 gm tube	
	<input type="checkbox"/> Androxy tablet	<input type="checkbox"/> Testim 1% gel 5 gm tube	<input type="checkbox"/> Testred capsule	
	<input type="checkbox"/> Aveed injection	<input type="checkbox"/> Testopel pellets	<input type="checkbox"/> Vogelxo 1% gel pump	
	<input type="checkbox"/> Axiron topical solution	<input type="checkbox"/> testosterone enanthate injection	<input type="checkbox"/> Vogelxo 1% gel 5 gm packet	
	<input type="checkbox"/> Depo-Testosterone injection	<input type="checkbox"/> testosterone 10 mg gel pump	<input type="checkbox"/> Vogelxo 1% gel 5 gm tube	
	<input type="checkbox"/> Fortesta gel pump	<input type="checkbox"/> testosterone 1% gel pump	<input type="checkbox"/> _____	
Strength: _____	Dose/directions: _____		Quantity: _____	Refills: _____
Diagnosis ( <u>submit documentation</u> ): _____			Dx code ( <u>required</u> ): _____	

#### Requests for ALL agents

1. Is the requested medication prescribed for an indication that is supported by a drug reference, medical literature, and/or national treatment guidelines?	<input type="checkbox"/> Yes <input type="checkbox"/> No – <u>Submit documentation supporting the use of the requested agent for the Recipient's diagnosis.</u>
2. If male, does the Recipient have lab results for a recent testosterone level?	<input type="checkbox"/> Yes – <u>Submit test results.</u> <input type="checkbox"/> No

#### Non-Preferred Requests

3. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Androgenic Agents? <i>Check all that apply.</i>	<input type="checkbox"/> Yes – <u>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.</u> <input type="checkbox"/> No
<input type="checkbox"/> Androgel 1% or 1.62% gel	
<input type="checkbox"/> oxandrolone tablet	
<input type="checkbox"/> testosterone cypionate injection	

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature: _____	Date: _____
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