pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANDROGENIC AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Androgenic Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: __________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Preferred medication requested (clinical prior authorization required):

- ☐Androderm patch
- ☐Androgel 1% gel 2.5 gm packet
- ☐Androgel 1% gel 5 gm packet
- ☐Androgel 1.62% gel pump
- ☐Androgel 1.62% gel 1.25 gm packet
- ☐Androgel 1.62% gel 2.5 gm packet
- ☐Methitest tablet
- ☐oxandrolone tablet
- ☐testosterone cypionate injection

Non-preferred medication requested:

- ☐Anadrol-50 tablet
- ☐Android capsule
- ☐Aveed injection
- ☐Depo-Testosterone injection
- ☐Fortesta 10 mg (2%) gel pump
- ☐methyltestosterone capsule
- ☐Striant mucoadhesive tablet
- ☐Testim 1% gel 5 gm tube
- ☐Testopel pellets
- ☐testosterone enanthate injection
- ☐testosterone 1% gel 2.5 gm packet
- ☐testosterone 1% gel 5 gm packet
- ☐testosterone 1% gel pump
- ☐testosterone 1% gel 5 gm tube
- ☐testosterone 1.62% gel 1.25 gm packet
- ☐testosterone 1.62% gel 2.5 gm packet
- ☐testosterone 10 mg (2%) gel pump
- ☐testosterone 30 mg/1.5 ml pump sol'n
- ☐Testred capsule
- ☐Vogelxo 1% gel pump
- ☐Vogelxo 1% gel 5 gm packet
- ☐Vogelxo 1% gel 5 gm tube
- ☐____________________

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (*required*):	

Requests for ALL agents

Question	Response
1. Is the requested medication prescribed for an indication that is supported by a drug reference, medical literature, and/or national treatment guidelines?	☐Yes ☐No – *Submit medical literature supporting the use of the requested agent for the beneficiary's diagnosis.*
2. If male, does the beneficiary have lab results for a recent testosterone level?	☐Yes – *Submit test results.* ☐No

Non-preferred requests

Question	Response	
3. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Androgenic Agents? *Check all that apply.* ☐Androderm patch ☐Androgel 1% or 1.62% gel ☐Methitest tablet ☐oxandrolone tablet ☐testosterone cypionate injection	☐Yes ☐No	*Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*

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

Prescriber Signature:	Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.