

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 <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary 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 (<i>submit documentation</i>):		Dx code (<i>required</i>):	
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 – <i>Submit medical literature supporting the use of the requested agent for the beneficiary's diagnosis.</i>	
If male, does the beneficiary have lab results for a recent testosterone level?		<input type="checkbox"/> Yes – <i>Submit test results.</i> <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
<u>Requests for a non-preferred medication:</u> Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Androgenic Agents? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.</i>	

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

Prescriber Signature:	Date:
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