FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Androgens Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Gender dysphoria

❑ Hypogonadism (primary or secondary)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Gender dysphoria:

Is the requested medication being used for hormone therapy? ❑ **Yes** ❑ **No**

Is there documentation of persistent, well-documented gender dysphoria diagnosed in accordance with criteria established in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5)? ❑ **Yes** ❑ **No**

Hypogonadism (primary or secondary):

Does the patient have a history of breast cancer? ❑ **Yes** ❑ **No**

Does the patient have a history of prostate cancer? ❑ **Yes** ❑ **No**

If **yes**, is the patient status post prostatectomy and there is documentation that the risk versus benefit has been assessed? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to or inability to tolerate generic transdermal testosterone? ❑ **Yes** ❑ **No**

Please document the following (new starts only):

Morning Testosterone Level: _____ Reference range: _____

Prolactin Level: _____ Reference range: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.