



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

Androgens Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> 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.

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