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

☐New request ☐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 *(submit documentation)*:	Dx code (*required*):	
For a non-preferred Androgenic Agent: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred drugs in this class approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes – *Submit documentation.* ☐No	
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.*	
If being treated for hypogonadism: Does the beneficiary have clinical and laboratory findings (such as testosterone, LH, FSH) that support the diagnosis?	☐Yes – *Submit documentation.* ☐No	
If being treated for gender dysphoria: Is the requested medication prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine?	☐Yes ☐No	*Submit documentation of consultation if applicable.*
If being treated for gender dysphoria: Is the requested medication prescribed in a manner consistent with current WPATH standards of care?	☐Yes ☐No	*Submit documentation.*

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

Prescriber Signature:	Date: