ANDROGENS/ANABOLIC STEROIDS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Please select the patient's diagnosis:

☐ AIDS/HIV-associated wasting syndrome
☐ Primary or secondary (hypogonadotropic) hypogonadism
☐ Myeloproliferative neoplasms
☐ Endometriosis amenable to hormone management
☐ Bone pain frequently accompanying osteoporosis
☐ To promote weight gain
☐ Gender identity disorder (GID), gender dysphoria, gender incongruence
☐ Other (ICD code, plus description): _____
☐ Metastatic/inoperable breast cancer
☐ Delayed puberty in an adolescent
☐ Angioedema, and will be taking for the prevention of attacks
☐ Fibrocystic breast disease
☐ Turner syndrome

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently being treated with the requested agent? ☐ Yes ☐ No
   If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** ☐ Yes ☐ No
2. Will the patient be using the requested agent in combination with another androgen or anabolic steroid agent for the requested indication? ☐ Yes ☐ No
   If yes, is there support for therapy with more than one agent? ☐ Yes ☐ No
   If yes, please provide supporting information: _____
3. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: _____
4. Will the patient use the requested agent in combination with an aromatase inhibitor (e.g. anastrozole, letrozole, exemestane, Femara, Kisqali), an antiestrogen (e.g., tamoxifen, toremifene), OR a selective estrogen receptor modulator (SERM, e.g., clomiphene, raloxifene, Osphena)? ☐ Yes ☐ No
   If yes, will the patient be using this combination for appearance enhancement or performance enhancement (e.g., bodybuilding)? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

5. Is the requested quantity (dose) greater than the maximum FDA labeled dose for the requested indication? ☐ Yes ☐ No
   If yes, please provide rationale in support of therapy with a higher dose for the requested indication: _____
   _____
   If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength? ☐ Yes ☐ No
   If no, please explain: _____
   _____
6. Is the request for one of the following brand agents: Androderm, Androgel, Fortesta, Natesto, Testim, Testosterone gel, Vogelxo, Aveed, Depo-Testosterone, Testopel, Xyosted, Jatenzo, Tlandod, Methitest, or Methyltestosterone capsule? ☐ Yes ☐ No

If yes, please answer the following (chart notes are required to support the answers):

- Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? ☐ Yes ☐ No
- Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** ☐ Yes ☐ No
- If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? ☐ Yes ☐ No
- Has the patient tried and had an inadequate response to a generic androgen or anabolic steroid that is supported for use for the requested indication? ☐ Yes ☐ No
  If yes, please specify: _____
  _____
- Was the generic androgen or anabolic steroid agent that is supported for use for the requested indication was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
- Does the patient have an intolerance, or hypersensitivity to the generic androgen or anabolic steroid agent that is supported for use for the requested indication that is not expected to occur with the brand agent? ☐ Yes ☐ No
- Does the patient have an FDA labeled contraindication to the generic androgen or anabolic steroid agent that is supported for use for the requested indication that is not expected to occur with the brand agent? ☐ Yes ☐ No
- Is the generic androgen or anabolic steroid agent that is supported for use for the requested indication expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
- Is the generic androgen or anabolic steroid agent that is supported for use for the requested indication not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic androgen or anabolic steroid agent that is supported for use for the requested indication and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

For hypogonadism requests:

7. Is the patient currently receiving testosterone replacement therapy? ☐ Yes ☐ No
   If no:
   - Does the patient have TWO pretreatment or current serum testosterone levels (free or total) measured in the morning (between 7am and 11am) on two separate days that are below the testing laboratory's normal range? **Please note, lab results are required** ☐ Yes ☐ No
   - Has the patient had one sign/symptom of hypogonadism? ☐ Yes ☐ No

   If yes:
   - Is the patient's current total serum testosterone level or free serum testosterone level below or within the testing laboratory's normal range? **Please note, lab results are required** ☐ Yes ☐ No

For gender identity disorder (GID), gender dysphoria, of gender incongruence requests:

8. When was treatment initiated? _____
9. Has the provider instituted a period of time where treatment is systematically reduced? ☐ Yes ☐ No
10. How old is the patient (in years)? Please select one and answer the corresponding questions:

☐ 17 years of age or younger

******If the patient is initiating sex hormone treatment, please answer the following:***

11. Is the patient 16 years of age or older? ☐ Yes ☐ No
    If no, please provide information to support initiating therapy prior to 16 years of age: _____
    _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

12. Was a persistent diagnosis confirmed by a mental health professional and/or trained physician who is trained in child and adolescent developmental psychopathology? ☐ Yes ☐ No
13. Has the patient's indication for sex hormone treatment been confirmed by an endocrinologist or a clinician experienced in pubertal sex hormone induction? ☐ Yes ☐ No
14. Does the patient have any medical contraindications to sex hormone treatment as confirmed by an endocrinologist or clinician experienced in pubertal sex hormone induction? ☐ Yes ☐ No
15. Has the patient been informed and counseled regarding effects and side effects of sex hormone treatment including those which are irreversible, and regarding loss of fertility and options to preserve fertility? ☐ Yes ☐ No
16. Does the patient have sufficient mental capacity to give consent? ☐ Yes ☐ No
17. Has the patient provided consent AND, as applicable, the parents or other caretakers or guardians have provided consent to therapy? ☐ Yes ☐ No
18. Have the patient's coexisting psychological, medical, or social problems that could interfere with treatment been addressed and the patient's functioning is stable enough to start sex hormone therapy? ☐ Yes ☐ No
19. Where will the patient be receiving treatment? Please select one and answer the corresponding questions:
    ☐ Alabama ☐ Florida ☐ Idaho ☐ Indiana ☐ Kentucky
    ☐ Louisiana ☐ Mississippi ☐ North Carolina ☐ North Dakota ☐ Oklahoma
    ☐ South Dakota ☐ Tennessee ☐ Other ☐ Unknown

******If the patient is continuing sex hormone treatment, please answer the following:***

20. Is the patient being monitored at least once yearly? ☐ Yes ☐ No
21. Where will the patient be receiving treatment? Please select one and answer the corresponding questions:
    ☐ Alabama
    ☐ Florida
    - Did treatment begin prior to 05/17/23 with parental consent? ☐ Yes ☐ No

    ☐ Indiana
    ☐ Iowa
    ☐ Kentucky
    - Has the provider documented that immediately terminating the minor's use of the treatment would cause harm to the patient? ☐ Yes ☐ No
    - Has the provider instituted a period of time where treatment is systematically reduced? ☐ Yes ☐ No

    ☐ Louisiana
    - Did treatment begin prior to 01/01/2024? ☐ Yes ☐ No
    - Has the provider documented that immediately terminating the minor's use of the treatment would cause harm to the patient? ☐ Yes ☐ No
    - Has the provider instituted a period of time where treatment is systematically reduced ending 12/31/2024? ☐ Yes ☐ No

    ☐ Mississippi
    ☐ North Carolina
    - Did treatment begin prior to 08/01/2023? ☐ Yes ☐ No

    ☐ North Dakota
    - Did treatment begin prior to 04/21/2023? ☐ Yes ☐ No

    ☐ Oklahoma
    ☐ South Dakota
    ☐ Tennessee
    ☐ Other
    ☐ Unknown

☐ 18 years of age or older

******If the patient is initiating sex hormone treatment, please answer the following:***

22. Has a persistent diagnosis been confirmed by a mental health professional? ☐ Yes ☐ No
23. Does the patient have sufficient mental capacity to give consent? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

24. Have the patient's medical conditions that can be exacerbated by treatment with sex hormones been evaluated and addressed? ☐ Yes ☐ No
25. Does the patient have coexisting mental health concerns? ☐ Yes ☐ No
    If yes, are the patient's coexisting mental health concerns reasonably well controlled? ☐ Yes ☐ No
26. Will the patient be receiving treatment in Florida? ☐ Yes ☐ No
    If yes, has the patient provided written informed consent? ☐ Yes ☐ No
    If yes, was their written informed consent provided from an in-person visit with a physician? ☐ Yes ☐ No

******If the patient is continuing sex hormone treatment, please answer the following:***

27. Is the patient being monitored at least once yearly? ☐ Yes ☐ No
28. Does the patient have a current total serum testosterone level that is within or below the testing laboratory's normal range OR is less than 300 ng/dL? ☐ Yes ☐ No
    If no, does the patient have a current free serum testosterone level that is within or below the testing laboratory's normal range? ☐ Yes ☐ No
    If no, is there support for continuing therapy with the patient's current testosterone level? ☐ Yes ☐ No
29. Will the patient be receiving treatment in Florida? ☐ Yes ☐ No
    If yes, has the patient provided written informed consent? ☐ Yes ☐ No
    If yes, was their written informed consent provided from an in-person visit with a physician? ☐ Yes ☐ No

For AIDs/HIV-associated wasting syndrome requests:

30. Has the patient had an unintentional weight loss that meets ONE of the following: 1) 10% within 12 months 2) 7.5% within 6 months? ☐ Yes ☐ No
31. Has the patient had a body cell mass (BCM) loss ≥ 5% within 6 months? ☐ Yes ☐ No
32. Is the patient's sex male and has a BCM < 35% of total body weight and body mass index (BMI) < 27 kg/m^2? ☐ Yes ☐ No
33. Is the patient's sex female and has BCM < 23% of total body weight and BMI < 27 kg/m^2? ☐ Yes ☐ No
    If no to the above two questions: is there support that the patient's BCM less than 35 percent or less than 23 percent and BMI less than 27 kg/m2 are medically appropriate for diagnosing AIDS wasting/cachexia for the patient's sex? ☐ Yes ☐ No
34. Have all other causes of weight loss been ruled out? ☐ Yes ☐ No

For delayed puberty in an adolescent requests:

35. Is the patient's sex female? ☐ Yes ☐ No
    If no, is there support that the requested agent is medically appropriate for the patient's sex? ☐ Yes ☐ No

For metastatic/inoperable breast cancer requests:

36. Is the patient's sex male? ☐ Yes ☐ No
    If no, is there support that the requested agent is medically appropriate for the patient's sex? ☐ Yes ☐ No

For myeloproliferative neoplasms requests:

37. Does the patient have a serum EPO greater than or equal to 500 mU/mL? ☐ Yes ☐ No
38. Does the patient have a serum EPO <500 mU/mL? ☐ Yes ☐ No
    If yes, has the patient had no response or loss of response to erythropoietic stimulating agents? ☐ Yes ☐ No

For requests to promote weight gain:

39. Does the patient have ONE of the following: 1) weight loss following extensive surgery, 2) chronic infections, 3) severe trauma, 4) failure to gain or maintain normal weight without definite pathophysiologic reasons, or 5) a prolonged administration of corticosteroids? ☐ Yes ☐ No

For Turner syndrome requests:

40. Will the requested agent be used in conjunction with growth hormone (GH)? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For renewal requests:

41. Has the patient had clinical benefit with the requested agent? ☐ Yes ☐ No

If yes, please explain:_____

_____

For hypogonadism requests:

42. Does the patient have a diagnosis of primary or secondary hypogonadism? ☐ Yes ☐ No

If yes, does the patient have a current total serum testosterone level that is within OR below the testing laboratory's normal range OR is less than 300 ng/dL? ☐ Yes ☐ No

If yes, does the patient have a current free serum testosterone level that is within OR below the testing laboratory's normal range? ☐ Yes ☐ No

For gender identity disorder (GID), gender dysphoria, or gender incongruence:

43. Is the patient being monitored at least once per year? ☐ Yes ☐ No

44. How old is the patient (in years)? Please select one and answer the corresponding questions:

☐ 17 years of age or younger

45. Where will the patient be receiving treatment? Please select one and answer the corresponding questions:

☐ Alabama

☐ Florida

- Did treatment begin prior to 05/17/23 with parental consent? ☐ Yes ☐ No

☐ Indiana

☐ Iowa

☐ Kentucky

- Has the provider documented that immediately terminating the minor's use of the treatment would cause harm to the patient? ☐ Yes ☐ No
- Has the provider instituted a period of time where treatment is systematically reduced? ☐ Yes ☐ No

☐ Louisiana

- Did treatment begin prior to 01/01/2024? ☐ Yes ☐ No
- Has the provider documented that immediately terminating the minor's use of the treatment would cause harm to the patient? ☐ Yes ☐ No
- Has the provider instituted a period of time where treatment is systematically reduced ending 12/31/2024? ☐ Yes ☐ No

☐ Mississippi

☐ North Carolina

- Did treatment begin prior to 08/01/2023? ☐ Yes ☐ No

☐ North Dakota

- Did treatment begin prior to 04/21/2023? ☐ Yes ☐ No

☐ Oklahoma

☐ South Dakota

☐ Tennessee

☐ Other

☐ Unknown

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

☐ 18 years of age or older

46. Does the patient have a current total serum testosterone level that is within or below the testing laboratory's normal range or is less than 300 ng/dL? ☐ Yes ☐ No
    If no, does the patient have a free serum testosterone level that is within or below the testing laboratory's normal range? ☐ Yes ☐ No
        If no, is there information to support continuing therapy with patient's current testosterone level? ☐ Yes ☐ No
47. Will the patient be receiving treatment in Florida? ☐ Yes ☐ No
    If yes, has the patient provided written informed consent? ☐ Yes ☐ No
        If yes, was their written informed consent provided from an in-person visit with a physician? ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525