

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:

- Primary or secondary (hypogonadotropic) hypogonadism
- Gender dysphoria/gender incongruence
- Myelofibrosis associated anemia
- Gender de-transition
- Breast cancer
- Delayed puberty in an adolescent
- Other (ICD code, plus description): _____

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

For all requests:

- 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
- 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, please provide support for therapy with more than one agent: _____
- Does the patient have any FDA labeled contraindications to the requested agent?..... Yes No
If yes, please specify FDA labeled contraindications: _____
- 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 list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

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

6. Is the request for one of the following brand agents: Androderm, Androgel, Aveded, Azmiro, Depo-Testosterone, Fortesta, Jatenzo, Kyzatrex, Methitest, Natesto, Testim, Testopel, Testosterone gel, Tlando, Undecatrex, Vogelxo, or Xyosted? Yes No

If yes, please answer the following questions:

- 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

Please submit chart notes to support the answers the following questions:

- 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
- Was a 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 a 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 ALL generic androgen or anabolic steroid agents that are supported for use for the requested indication that is not expected to occur with the brand agent? Yes No
- Is a 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 a 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 a 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
- Does the patient have a sign or 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 dysphoria/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 support for initiating therapy prior to 16 years of age: _____

Please continue to the next page.

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

12. Has a comprehensive biopsychosocial assessment been conducted by a qualified physician AND has the prescriber consulted with other medical professionals (e.g., mental health professional, endocrinologist) when required? Yes No
13. Were the parents or other caretakers or guardians involved in the assessment process? Yes No
 If no, was the involvement of the parents or other caretakers or guardians determined to be harmful to the adolescent or not feasible? Yes No
14. Has a persistent diagnosis of gender dysphoria/gender incongruence been marked and sustained over time? .. 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 the potential loss of fertility and options available to preserve fertility? Yes No
16. Does the patient have sufficient emotional and cognitive maturity required to provide informed consent/assent for treatment? Yes No
17. Has the patient provided informed consent/assent for treatment AND, as applicable, the parents or other caretakers or guardians have provided consent to therapy? Yes No
18. Have the patient's coexisting mental health concerns, physical conditions, or social problems that may interfere with diagnosing and/or sex hormone treatment been addressed to provide optimal treatment? Yes No
19. Where will the patient be receiving treatment? Please select one and answer the corresponding questions:
- | | | | | | |
|---------------------------------------|--------------------------------------|-----------------------------------------|---------------------------------------|-----------------------------------|-----------------------------------------|
| <input type="checkbox"/> Alabama | <input type="checkbox"/> Florida | <input type="checkbox"/> Idaho | <input type="checkbox"/> Indiana | <input type="checkbox"/> Iowa | <input type="checkbox"/> Kentucky |
| <input type="checkbox"/> Louisiana | <input type="checkbox"/> Mississippi | <input type="checkbox"/> North Carolina | <input type="checkbox"/> North Dakota | <input type="checkbox"/> Oklahoma | <input type="checkbox"/> South Carolina |
| <input type="checkbox"/> South Dakota | <input type="checkbox"/> Tennessee | <input type="checkbox"/> Texas | <input type="checkbox"/> Other | <input type="checkbox"/> 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:
- | | |
|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Alabama | |
| <input type="checkbox"/> Florida | • Did treatment begin prior to 05/17/23 with parental consent? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Idaho | |
| <input type="checkbox"/> Indiana | |
| <input type="checkbox"/> Iowa | |
| <input type="checkbox"/> Kentucky | • Has the provider documented that immediately terminating the minor's use of the treatment would cause harm to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Has the provider instituted a period of time where treatment is systematically reduced? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Louisiana | • Did treatment begin prior to 01/01/2024? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Has the provider documented that immediately terminating the minor's use of the treatment would cause harm to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Has the provider instituted a period of time where treatment is systematically reduced ending 12/31/2024? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Mississippi | |
| <input type="checkbox"/> North Carolina | • Did treatment begin prior to 08/01/2023? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> North Dakota | • Did treatment begin prior to 04/21/2023? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Oklahoma | |
| <input type="checkbox"/> Puerto Rico | |
| <input type="checkbox"/> South Carolina | • Did treatment begin prior to 08/01/2024? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Has the provider documented that immediately terminating the minor's use of the treatment would cause harm to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | • Has the provider instituted a period of time where treatment is systematically reduced ending 01/31/2025? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> South Dakota | |
| <input type="checkbox"/> Tennessee | |
| <input type="checkbox"/> Texas | |
| <input type="checkbox"/> Other | |
| <input type="checkbox"/> Unknown | |

Please continue to the next page.

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

18 years of age or older

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

22. Has a persistent diagnosis of gender dysphoria/gender incongruence been marked and sustained over time?.. Yes No
23. Have other possible causes of apparent gender incongruence been identified and excluded prior to initiation of treatment? Yes No
24. Has the patient been informed and counseled regarding effects and side effects of sex hormone treatment, including those which are irreversible, and the potential loss of fertility and options available to preserve fertility? Yes No
25. Does the patient have sufficient emotional and cognitive maturity required to provide informed consent for treatment? Yes No
26. Has the patient provided informed consent for treatment? Yes No
27. Have the patient's coexisting mental health and/or physical conditions that could have a negative impact on sex hormone treatment been addressed, with risks and benefits discussed, to provide optimal treatment?..... Yes No
28. 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:**

29. Is the patient being monitored at least once yearly? Yes No
30. Is the patient's current total serum testosterone level within OR below the testing laboratory's normal range for the patient's gender identity OR is less than 300 ng/dL? Yes No
 If no, is the patient's current free serum testosterone level within OR below the testing laboratory's normal range for the patient's gender identity? Yes No
 If no, is there support for continuing therapy with the patient's current testosterone level? Yes No
 If yes, please provide supporting information: _____
31. 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 delayed puberty in an adolescent requests:

32. 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
 If yes, please provide supporting information: _____

For breast cancer requests:

33. Is the 1 to 5 years postmenopausal? Yes No
 If yes, does the patient have inoperable metastatic breast cancer? Yes No
 If no, is the patient premenopausal? Yes No
 If yes, has the patient benefitted from oophorectomy? Yes No
 If yes, does the patient have a hormone-responsive tumor? Yes No

For myelofibrosis associated anemia requests:

34. Does the patient have a serum EPO greater than or equal to 500 mU/mL? Yes No
35. Does the patient have a serum EPO less than 500 mU/mL? Yes No
 If yes, has the patient had no response or loss of response to an erythropoiesis-stimulating agent (ESA)?.... Yes No

For renewal requests:

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

For primary or secondary hypogonadism renewal requests:

37. Is the patient's current total serum testosterone level within OR below the testing laboratory's normal range OR less than 300 ng/dL? Yes No
 If no, is the patient's current free serum testosterone level within OR below the testing laboratory's normal range? Yes No

Please continue to the next page.

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

For gender dysphoria/gender incongruence renewal requests:

38. Is the patient being monitored at least once per year? Yes No
39. How old is the patient (in years)? Please select one and answer the corresponding questions:
 17 years of age or younger
40. 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
 - Idaho
 - 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
 - Puerto Rico
 - South Carolina
 - Did treatment begin prior to 08/01/2024? 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 01/31/2025? Yes No
 - South Dakota
 - Tennessee
 - Texas
 - Other
 - Unknown
- 18 years of age or older
41. Is the patient's current total serum testosterone level within OR below the testing laboratory's normal range for the patient's gender identity OR is less than 300 ng/dL? Yes No
 If no, is the patient's current free serum testosterone level within OR below the testing laboratory's normal range for the patient's gender identity? Yes No
 If no, is there support for continuing therapy with patient's current testosterone level? Yes No
 If yes, please provide supporting information: _____
42. 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: **BCBSIL: 800.285.9426**
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

Fax: 877.243.6930

CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.