ANDROGENIC AGENTS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

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

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/star-kids-prior-auth

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX 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

Patient's Diagnosis- ICD code plus description:

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
2. Does the patient have a diagnosis of gender dysphoria in the last 730 days? ☐ Yes ☐ No
3. Does the patient have a diagnosis of hypogonadism in the last 730 days? ☐ Yes ☐ No
4. Is this an initial request? ☐ Yes ☐ No
   - If yes, is the patient's initial total testosterone less than 300 ng/dL, measured on 2 separate occasions? ☐ Yes ☐ No
     - If no, does the patient have a condition that may cause altered sex-hormone binding globulin (SHBG), and is the patient's initial free or bioavailable testosterone level less than 50 pg/mL? ☐ Yes ☐ No
   - If no, is the patient's current total testosterone less than or equal to 900 ng/dL? ☐ Yes ☐ No
5. Does the patient have a history of breast cancer or prostate cancer in the last 365 days? ☐ Yes ☐ No
6. Does the patient have a history of cardiac disease (including heart failure, coronary artery disease, and/or myocardial infarction) in the last 365 days? ☐ Yes ☐ No
7. Please list all reasons for selecting the **requested medication** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions). _____

_____

_____

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

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

TOLL FREE
Fax: 877.243.6930 **Phone: 855.457.1200**

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