GHP Family Pharmacy Customer Service
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Geisinger

ANDROGENIC AGENTS PRIOR AUTHORIZATION FORM *(form effective 01/05/2021)*

Prior authorization guidelines for Androgenic Agents and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐ New request ☐ Renewal request	Total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
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 each 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 each 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 submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date: