



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Androgenic Agents

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	PA PROMISe ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	
Quantity:	Refills:	
Directions:		
Diagnosis Code:	Diagnosis:	
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the requested drug being prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes

No

Q2. Is the patient prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q3. Does the patient have a history of a contraindication to the prescribed medication?

Yes

No

Q4. Does the patient have a diagnosis of hypogonadism?

Yes

No

Q5. Does the patient have clinical and laboratory findings (such as testosterone, luteinizing hormone [LH], follicle-stimulating hormone [FSH]) supporting the diagnosis?

Yes

No

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<p>Q6. Does the patient have a diagnosis of gender dysphoria?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q7. Is the requested drug prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q8. Is the requested drug prescribed in a manner consistent with the current World Professional Association for Transgender Health standards of care for the health of Transgender and Gender Diverse People?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q9. Is this a request for an androgenic agent when there is a paid claim for another androgenic agent (i.e., potential therapeutic duplication)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q10. Is the patient being titrated to, or tapered from, a drug in the same class?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q11. Has the prescriber provided a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q12. Is this a request for a preferred androgenic agent?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q13. Does the patient have a history of therapeutic failure of the preferred androgenic agents?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q14. Is this a request for a renewal of authorization?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Q15. Additional Information:

Q16. INTERNAL QUESTION #2: Is the request for: *

PRD Generic NPD PRD Brand Testopel

Prescriber Signature

Date

v2026-06