

## Androgenic Agents Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.**

**1. Patient information**
**2. Physician information**

Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____
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**3. Medication**
**4. Strength**
**5. Directions**
**6. Quantity per 30 days**

			Specify:
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**7. Diagnosis:**

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Is the medication being provided and billed at the physician's office?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Is the patient 18 years of age or older?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does the patient have a diagnosis of hypogonadism in the last 730 days?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does the patient have a history of breast cancer or prostate cancer in the last 365 days?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does the patient have a history of cardiac disease (including heart failure, coronary artery disease and/or myocardial infarction) in the last 365 days?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Patient has failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days.
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Patient has a documented allergy or contraindication to preferred agents in this class.
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <https://www.txvendordrug.com/formulary/formulary-search>

**9. Physician signature**

_____ Prescriber or authorized signature	_____ Date
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<https://provider.amerigroup.com/TX>

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

*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.*

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