**Note**: Processing may be delayed if information submitted is illegible or incomplete.

If your fax includes the standardized fax form, only the **Member Name**, **DOB**, **ID**, and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

# ENROLLEE INFORMATION

**Enrollee’s Last Name: Enrollee’s First Name:**

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**Date of Birth: Enrollee’s Medicaid ID (2 letters, 5 numbers, 1 letter):**

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**Address:**

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**City: State: Zip Code:**

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# PRESCRIBER INFORMATION

**Prescriber’s Last Name: Prescriber’s First Name:**

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**National Provider Identifier (NPI) Number: Board Certified Specialty:**

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**Address:**

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**City: State: Zip Code:**

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**Office Phone Number: Office Fax Number:**

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**Enrollee’s Last Name: Enrollee’s First Name:**

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# CLINICAL CRITERIA – DRUG INFORMATION

**Drug Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Strength:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Directions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Quantity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Prescription:** [ ]  Yes [ ]  No

If **NO**, date therapy initiated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Clinical Criteria – DIAGNOSIS

1. [ ]  Hypogonadotropic or primary hypogonadism

[ ]  Delayed puberty

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## For diagnosis of hypogonadotropic or primary hypogonadism:

2. Does the patient have documented low testosterone concentration with two tests? (Required prior to initiation of anabolic steroid therapy)

[ ]  Yes [ ]  No

1. If **YES**, please provide dates for the two tests indicating low testosterone concentrations:

Date 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the patient have documented therapeutic testosterone concentration, indicating response to therapy? (Required for continuation of anabolic steroid therapy)

[ ]  Yes [ ]  No

1. If **YES**, please provide date(s) for tests indicating therapeutic testosterone concentrations:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## For diagnosis of delayed puberty:

1. Has growth hormone deficiency been ruled out prior to initiation of anabolic steroid therapy?

[ ]  Yes [ ]  No

1. If **YES**, please provide date(s) for growth hormone deficiency tests:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Enrollee’s Last Name: Enrollee’s First Name:**

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# CLINICAL CRITERIA – DIAGNOSIS (*CONTINUED*)

## For other diagnoses:

1. Please provide clinical rationale and laboratory test results (if applicable) for the use of anabolic steroid:

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## Please answer the following questions if requesting a non-preferred anabolic steroid (a listing of preferred and non-preferred drugs can be found at <https://newyork.fhsc.com/>):

1. Is there a documented history of successful therapeutic control with a non-preferred agent?

[ ]  Yes [ ]  No

1. Has the patient experienced treatment failure or an adverse reaction with a preferred agent?

[ ]  Yes [ ]  No

|  |  |  |
| --- | --- | --- |
| Prescriber Signature (Required)*I attest that this anabolic steroid is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge.* |  | Date |

**Fax Number:** 1-800-268-2990

**Prior Authorization Call Line:** 1-877-309-9493

**Billing Questions:** 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit <http://newyork.fhsc.com> or call 1-877-309-9493.