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Prime THERAPEUTICS™

NYRx the Medicaid Pharmacy Program

Anabolic Steroids Prior Authorization Worksheet

Fax Number: 1-800-268-2990

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:** _____

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

Enrollee's Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

PRESCRIBER INFORMATION

Prescriber's Last Name: _____ **Prescriber's First Name:** _____

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

Prescriber's Street Address: _____

City: _____ **State:** _____ **Zip Code** _____

Prescriber's Phone Number: _____ **Prescriber's Fax Number:** _____

REQUESTED DRUG INFORMATION

Drug Name: _____ **Drug Strength:** _____

Quantity: _____ **Refills:** _____

Directions: _____

New Prescription: ☐ Yes ☐ No If **NO**, date therapy was initiated: _____

CLINICAL CRITERIA – DIAGNOSIS

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Enrollee's Last Name: **Enrollee's First Name:**

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
3. If **YES**, please provide dates for the two tests indicating low testosterone concentrations:
   Date 1: _____
   Date 2: _____
4. Does the patient have documented therapeutic testosterone concentration, indicating response to therapy? (Required for continuation of anabolic steroid therapy)
   ☐ Yes ☐ No
5. If **YES**, please provide date(s) for tests indicating therapeutic testosterone concentrations:
   Date(s): _____

For Diagnosis of Delayed Puberty

6. Has growth hormone deficiency been ruled out prior to initiation of anabolic steroid therapy?
   ☐ Yes ☐ No
   If **YES**, please provide date(s) for growth hormone deficiency tests.
   Date(s): _____

For Other Diagnoses

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

Enrollee's Last Name: **Enrollee's First Name:**

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/):

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

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

I attest that this anabolic steroid is medically necessary for this patient and that all the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.

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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.