Prior Authorization Request
Nevada Medicaid – Molina Healthcare

Topical Androgen Agents

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

DATE OF REQUEST:		
MEMBER INFORMATION		
Last name, First name, Middle initial:		Date of birth:
Molina ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:		NPI:
Phone:		Fax (required):
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Name:		Strength:
Dosage:		Duration:
Diagnosis **(REQUIRED)**: ☐ Primary (congenital) ☐ Secondary (congenital or acquired) hypogonadism ☐ Other (please specify):		

COVERAGE CRITERIA

Please check the applicable boxes to indicate each item as true for the recipient:

- ☐ The recipient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used.
- ☐ The recipient does not have a hematocrit > 50%.
- ☐ The recipient does not have untreated severe obstructive sleep apnea.
- ☐ The recipient does not have uncontrolled or poorly controlled heart failure.
- ☐ The recipient does not have breast or prostate cancer.
- ☐ The recipient does not have a palpable prostate nodule or induration.
- ☐ The recipient does not have a prostate-specific antigen >4 ng/ml.
- ☐ The recipient does not have severe lower urinary symptoms with an International Prostate Symptom Score (IPSS) > 19.

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature: _____ **Date:** _____

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.