

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**  
**Activella (estradiol/norethindrone acetate)**  
**Prior Authorization of Benefits (PAB) Form**  
**Complete form in its entirety and fax to:**  
**Prior Authorization of Benefits Center at (800) 601- 4829**

**1. PATIENT INFORMATION**

**2. PHYSICIAN INFORMATION**

|   |  |
|---|--|
| Patient Name: _____<br>Patient ID #: _____<br>Patient DOB: _____<br>Date of Rx: _____<br>Patient Phone #: _____<br>Patient Email Address: _____ | Prescribing Physician: _____<br>Physician Address: _____<br>Physician Phone #: _____<br>Physician Fax #: _____<br>Physician Specialty: _____<br>Physician DEA: _____<br>Physician NPI #: _____<br>Physician Email Address: _____ |
|---|--|

**3. MEDICATION**

**4. STRENGTH**

**5. DIRECTIONS**

**6. QUANTITY PER 30 DAYS**

|   |  |                |                |
|---|--|----------------|----------------|
| <input type="checkbox"/> Activella<br>(estradiol/norethindrone acetate) | <input type="checkbox"/> 0.5mg/0.1mg estradiol/<br>norethindrone acetate<br><input type="checkbox"/> 1mg/0.5mg estradiol/<br>norethindrone acetate | _____<br>_____ | Specify: _____ |
|---|--|----------------|----------------|

**7. DIAGNOSIS:** \_\_\_\_\_

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

|                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Patient is male                                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Patient has a diagnosis of advanced prostate cancer |

**9. PHYSICIAN SIGNATURE**

|  |               |
|--|---------------|
| _____<br>Prescriber or Authorized Signature  | _____<br>Date |
| <small><i>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.</i></small><br><small>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</small> |               |

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