

Prior Authorization Request Form for  
**Conjugated estrogen Tablets (Premarin)**



7231 Parkway Drive, Suite 100  
 Hanover, MD 21076

**Fax completed form and applicable progress notes to: (410) 424-4037**

## USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**Questions?** Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire. PA is NOT required for Premarin brand use in natal females. PA is required for natal males and for generic conjugated estrogen.

**Step 1** Please complete patient and physician information (please print):

<b>1</b> Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
Sponsor ID #	_____	Phone #:	_____
Date of Birth:	_____	Secure Fax #:	_____

**Step 2** Please complete the clinical assessment:

<b>1. What is the patient's sex?</b>	<input type="checkbox"/> Male – Proceed to question 2 <input type="checkbox"/> Female ( <b>Note: PA is NOT required for Premarin brand. PA is required for generic conjugated estrogen only</b> ) – Proceed to question 6
<b>2. How old is the patient?</b>	<input type="checkbox"/> 18 years of age or younger – Proceed to question 3 <input type="checkbox"/> 19 years of age or older – Proceed to question 4
<b>3. What is the indication or diagnosis?</b>	<input type="checkbox"/> Treatment of male to female hormone therapy in a natal male patient – <b>STOP - Coverage not approved</b> <input type="checkbox"/> Other diagnosis - Proceed to question 6
<b>4. What is the indication or diagnosis?</b>	<input type="checkbox"/> Initiation of male to female hormone therapy in a natal male patient – Proceed to question 5 <input type="checkbox"/> Continuation of male to female hormone therapy in a natal male patient – Proceed to question 6 <input type="checkbox"/> Other diagnosis - Proceed to question 6
<b>5. Is the patient a male active duty servicemember?</b>	<input type="checkbox"/> Yes (Male active duty servicemembers) – <b>STOP - Coverage not approved</b> <input type="checkbox"/> No (Male non-active duty servicemembers) - Proceed to question 6
<b>6. The provider acknowledges that the brand Premarin tablet is the preferred product over generic conjugated equine estrogen tablets and is covered at the lowest copayment, which is the generic formulary copayment for non-Active-Duty patients, and at no cost share for Active-Duty patients. (Although Premarin is a branded product, it will be covered at the generic formulary copayment or cost share).</b>	<input type="checkbox"/> <b>Acknowledged</b>  Proceed to question 7

Prior Authorization Request Form for  
**Conjugated estrogen Tablets (Premarin)**

7. Please provide a patient-specific justification as to why the brand Premarin product cannot be used in this patient.

---

**Sign and date below**

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date

[24 February 2026]

<b>For Internal Use Only</b>	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: