PRIOR AUTHORIZATION REQUEST
Testosterone Agents

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - ☐ INITIAL
   - ☐ CONTINUATION
2. What is the patient's indication/diagnosis?
   - ☐ Hypogonadism
   - ☐ Aids-Associated wasting
   - ☐ Delayed puberty
   - ☐ Palliative treatment of inoperable breast cancer in women
   - ☐ Transgender
   - ☐ All other indications/diagnosis ***(Please specify):***_____

If patient's indication/diagnosis is ***Hypogonadism***, please answer questions 3 – 21

For ***INITIAL THERAPY***, please answer questions 3 – 19

3.	☐ Yes	☐ No	Has the diagnosis been confirmed by two separate A.M. serum testosterone measurements with results below normal range?
4.	☐ Yes	☐ No	Does the patient have AT LEAST one low total testosterone level (below the normal range for the laboratory) WITH elevated follicle-stimulating hormone (FSH) and/or luteinizing hormone (LH)?
5.	☐ Yes	☐ No	If answer is **No** from previous question, does the patient have AT LEAST two total testosterone levels, both of which are LESS THAN normal based upon the laboratory reference range WITH AT LEAST one low free testosterone level (below the normal range for the laboratory)?
6.	☐ Yes	☐ No	Does the patient have breast discomfort or gynecomastia?
7.	☐ Yes	☐ No	Does the patient have any loss of body (axillary and pubic) hair? ***Note: Reduced shaving if needed.***
8.	☐ Yes	☐ No	Does the patient have very small (especially LESS THAN 5 mL) or shrinking testes?
9.	☐ Yes	☐ No	Does the patient have the inability to father children or have low/zero sperm count?
10.	☐ Yes	☐ No	Does the patient have height loss, low trauma fracture, or low bone mineral density?
11.	☐ Yes	☐ No	Does the patient have hot flushes and/or sweats?

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If you have any questions, call: 800-753-2851

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12. ☐ Yes ☐ No Does the patient have any less specific signs and symptoms including decreased, energy, depressed mood/dysthymia, irritability, sleep disturbance, poor concentration/memory, diminished physical or work performance?
13. ☐ Yes ☐ No Does the patient not have metastatic prostate cancer?
14. ☐ Yes ☐ No Does the patient not have breast cancer?
15. ☐ Yes ☐ No Does the patient not have unevaluated prostate nodule or induration?
16. ☐ Yes ☐ No Does the patient not have a prostate-specific antigen (PSA) GREATER THAN 4 ng/ml?
17. ☐ Yes ☐ No Does the patient not have a hematocrit GREATER THAN 50%?
18. ☐ Yes ☐ No Does the patient not have an uncontrolled or poorly controlled congestive heart failure?
19. ☐ Yes ☐ No Does the patient have severe lower urinary tract symptoms associated with benign prostatic hypertrophy as indicated by AUA/IPSS GREATER THAN 19?

For ***CONTINUATION THERAPY***, please answer questions 20 and 21

20. ☐ Yes ☐ No Is the patient's testosterone level within normal range?
21. ☐ Yes ☐ No Has the patient shown an improvement in symptoms?

If patient's indication/diagnosis ***Aids-Associated wasting,*** please answer questions 22 – 32

22. ☐ Yes ☐ No Is there documentation which confirms the diagnosis by two separate A.M. serum testosterone measurements with results below normal range as evidenced?
23. ☐ Yes ☐ No Does the patient have AT LEAST one low total testosterone level (below the normal range for the laboratory) WITH elevated follicle-stimulating hormone (FSH) and/or luteinizing hormone (LH)?
24. ☐ Yes ☐ No If answer is **No** from previous question, does the patient have AT LEAST two total testosterone levels, both of which are LESS THAN normal based upon the laboratory reference range WITH AT LEAST one low free testosterone level (below the normal range for the laboratory)?
25. ☐ Yes ☐ No Does the patient have breast discomfort or gynecomastia?
26. ☐ Yes ☐ No Does the patient have any loss of body (axillary and pubic) hair?
27. ☐ Yes ☐ No Does the patient have very small (especially LESS THAN 5 mL) or shrinking testes?
28. ☐ Yes ☐ No Does the patient have the inability to father children or have low/zero sperm count?
29. ☐ Yes ☐ No Does the patient have height loss, low trauma fracture, or low bone mineral density?
30. ☐ Yes ☐ No Does the patient have hot flushes and/or sweats?
31. ☐ Yes ☐ No Does the patient have any less specific signs and symptoms including decreased, energy, depressed mood/dysthymia, irritability, sleep disturbance, poor concentration/memory, diminished physical or work performance?
32. ☐ Yes ☐ No Is there documentation that the patient has adequate nutritional support/caloric intake?

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If patient's indication/diagnosis ***Delayed puberty***, please answer questions 33 and 34

For ***INITIAL THERAPY***, please answer question 33 only

33. ☐ Yes ☐ No Was the baseline x-ray of the hand and wrist completed to determine bone age?

For ***CONTINUATION THERAPY***, please answer question 34 only

34. ☐ Yes ☐ No Did the patient undergo a X-ray of the hand and wrist every 6 months to determine bone age and to assess the effect of treatment on the epiphyseal centers?

If patient's indication/diagnosis ***Palliative treatment of inoperable breast cancer in women***, please answer question 35 only

35. ☐ Yes ☐ No Is the requested medication being prescribed by an oncologist?

If patient's indication/diagnosis ***Transgender***, please answer question 36 only

36. ☐ Yes ☐ No Did the patient undergo a gender change from female to male or is currently in the process of transitioning?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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