PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

TESTOSTERONE PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber ID Number		Group Number	
Patient Name	Patient Telephone Number		Date of Birth
Patient Address	City	State	Zip Code

PRESCRIBER INFORMATION

Physician Name	Phone		Fax
Physician Address	City	State	Zip Code
Suite / Building	Physician Signature		Date

MEDICATION INFORMATION

Requested Drug:	Quantity per Month
Diagnosis:	

CLINICAL CRITERIA

1. Does the patient have primary or secondary hypogonadism with testicular failure due to any of the following?

   ☐ Double orchidectomy ☐ Cryptorchidism ☐ Bilateral torsions ☐ Orchitis
   ☐ Vanishing testis syndrome ☐ Single orchidectomy ☐ Klinefelter's syndrome
   ☐ Chemotherapy damage ☐ Radiation damage ☐ Toxic damage

2. Does the patient have any of the following symptoms of hypogonadism?
   ☐ Height loss due to vertebral fractures ☐ Low bone density ☐ Breast discomfort
   ☐ Loss of axillar and/or pubic body hair ☐ Low trauma fractures ☐ Hot flushes
   ☐ Incomplete or delayed sexual development (i.e. delayed puberty)

3. Is testosterone therapy being used for a patient with any of the following?
   ☐ Weight loss due to HIV infection
   ☐ Chronic steroid treatment
   ☐ Metastatic breast cancer for palliative treatment

4. Does the patient have gender dysphoria or gender identity disorder?
   If **YES**:
   a. Is masculinization the goal of testosterone therapy? ☐ Yes ☐ No
   b. Is this being prescribed by an endocrinologist or provider that specializes in gender affirmation? ☐ Yes ☐ No

5. If the request is for ***brand*** Androgel 1%, Androgel 1.62%, Fortesta, Testim, Vogelxo, Natesto, Jatenzo, or Xyosted, has the patient experienced therapeutic failure or intolerance to a generic topical testosterone product?
   ☐ Yes ☐ No

6. If the request is for ***brand*** Android or Testred, has the patient experienced therapeutic failure or intolerance to generic methyltestosterone? ☐ Yes ☐ No

7. Is this a request for reauthorization? ☐ Yes ☐ No
   If **YES**:
   a. Has the patient experienced a positive clinical response to testosterone therapy? ☐ Yes ☐ No
   b. Does the member require additional therapy with the requested product? ☐ Yes ☐ No

Please provide 2 morning (before 11:00 AM) PRE-treatment Total Testosterone levels and Free Testosterone levels with reference ranges along with dates and times collected:

	Level	Normal Range	Date Collected	Time Collected
Total Testosterone				
Free Testosterone				
Total Testosterone				
Free Testosterone				

-If the member is not producing any testosterone, please check this box: ☐

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. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222