FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Androgens Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Delayed puberty
❑ Gender dysphoria
❑ Hypogonadism (e.g., testicular hypofunction, male hypogonadism, ICD-10 code E29.1)
❑ Inoperable breast cancer, palliative treatment
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Continuation of therapy:

Is this a continuation of testosterone therapy? ❑ **Yes** ❑ **No**

Which gender was the patient at birth? (Select from one of the options below)

❑ Female
❑ Male

Medication History:

For nasal, oral, & topical testosterone requests, select the medications the patient has a failure, contraindication, or intolerance to:

❑ Androderm (testosterone patch)
❑ Androgel 1% (testosterone gel)
❑ Androgel 1.62% gel (testosterone gel)
❑ Androgel 1.62% pump (testosterone pump)
❑ Fortesta (testosterone gel)
❑ Testim (testosterone gel)

For implant & injectable testosterone requests, select the medications the patient has a failure, contraindication, or intolerance to:

❑Testosterone cypionate
❑ Testosterone enanthate

Hypogonadism in men (e.g., testicular hypofunction, male hypogonadism, ICD-10 code E29.1):

Does the patient have a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? ❑ **Yes** ❑ **No**

Does the patient have a history of one of the following: Bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)? ❑ **Yes** ❑ **No**

Laboratory information:

Total testosterone level:

Does the patient have two pre-treatment serum total testosterone levels less than 300ng/dL (< 10.4 nmol/L) or less than the reference range for the lab? ❑ **Yes** ❑ **No**

Calculated free or bioavailable testosterone level:

Does the patient have one pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (< 0.17 nmol/L) or less than the reference range for the lab? ❑ **Yes** ❑ **No**

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Gender dysphoria:

Is the patient a female-to-male transsexual? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is the patient's follow-up **total serum** testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy, within or below the normal limits of the reporting lab? ❑ **Yes** ❑ **No**

Is the patient's follow-up **total serum** testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy, outside of the upper limits of normal for the reporting lab and the dose has been adjusted? ❑ **Yes** ❑ **No**

Is the patient's follow-up **calculated free or bioavailable** testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy, within or below the normal limits of the reporting lab? ❑ **Yes** ❑ **No**

Is the patient's follow-up **calculated free or bioavailable** testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy, outside of the upper limits of normal for the reporting lab and the dose has been adjusted? ❑ **Yes** ❑ **No**

Does the patient have a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.