HIGHMARK | HIGHMARK

Medication Prior Authorization Form
Fax to 1-866-240-8123

Testosterone

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

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

Medication Information:

Drug Name	Requested Quantity	Requested Day Supply
		☐ 30 days ☐ 90 days ☐ Other: _____
Directions		
Diagnosis and/or ICD-10 code(s)		

Clinical Information:

1. Does the member have a diagnosis of hypogonadism?	Yes	No
If the member has hypogonadism, please answer the following:		
1a. Has the member had at least 1 low pre-treatment total testosterone level less than 300 ng/dL (10.4 nmol/L) or near the lower limit of the normal range per the laboratory reference range (bottom 20 percent of the reference range?	Yes	No

1a. 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:

****Please provide documentation of lab results for verification.**

	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: ☐

-If the member's pre-treatment medical records are not available, please check this box: ☐

1b. Does the member 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 ☐ Surgery damage

1c. Does the member have any of the following symptoms of low testosterone?

☐ Reduced sexual desire (libido) and activity ☐ Hot flushes, sweats
☐ Loss of (axillary and pubic) hair ☐ Very small testes ☐ Eunuchoidal body proportions
☐ Incomplete or delayed sexual development ☐ Inability to father children, low sperm count
☐ Height loss, low-trauma fracture, low bone mineral density ☐ Breast discomfort, gynecomastia

1d. Does the member have a diagnosis of secondary hypogonadism due to hypopituitarism (pituitary hormone deficiencies)?	Yes	No
2. Does the member have a diagnosis of gender dysphoria or gender identity disorder?	Yes	No

If the member has gender dysphoria or gender identity disorder, please answer the following:

2a. If the member is 15 years of age or younger, is the requested testosterone product being prescribed by a clinician competent in the evaluation and induction of pubertal development?	Yes	No

3. Is testosterone therapy being used for a member with any of the following?

☐ Chronic steroid treatment
☐ Weight loss due to HIV infection
☐ Metastatic breast cancer for palliative treatment
☐ Diagnosis of delayed puberty

4. Is the member currently on testosterone therapy?	Yes	No
If the member is currently on testosterone therapy, please answer the following:		
4a. Has the member experienced a positive clinical response to testosterone therapy?	Yes	No
4b. Does the member require continued therapy with the requested testosterone product?	Yes	No
4c. Is the dosage of the medication being adjusted?	Yes	No
If the member has hypogonadism, please answer the following:		

4d. Please provide the member's total and free testosterone level within the past 12 months:

****Please provide documentation of lab results for verification.**

	Level	Normal Range	Date Collected
Total Testosterone			
Free Testosterone			

Medication History:

5. Please provide any other medications that the member has tried and failed:

_____

_____

_____

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 member. 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. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**