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

TESTOSTERONE PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

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

PRESCRIBER INFORMATION

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

MEDICATION INFORMATION

Requested Drug:	Quantity per Month
Diagnosis:	

CLINICAL CRITERIA

1. Does the member have a diagnosis of hypogonadism?
   ☐ Yes ☐ No
   If **YES**:
   a. 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 patient is not producing any testosterone, please check this box:** ☐

b. 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 ☐ Surgery damage

c. Does the patient 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

d. Does the patient have a diagnosis of secondary hypogonadism due to hypopituitarism (pituitary hormone deficiencies)?
☐ Yes ☐ No

2. Does the patient have a diagnosis of gender dysphoria or gender identity disorder?
☐ Yes ☐ No
If **YES**:
a. If the patient 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 ☐ N/A

3. Is testosterone therapy being used for a patient 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 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 patient require continued therapy with the requested testosterone product?
☐ Yes ☐ No

5. Please provide any other medications previously tried and failed for the patient's diagnosis:

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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