Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Androgens Prior Authorization Request Form (Page 1 of 2)

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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 requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the requested drug below:

- ❑ Androgel 1.62%
- ❑ Androgel 1.62% pump
- ❑ Testosterone cypionate IM injection (generic Depo-Testosterone)
- ❑ Testosterone enanthate IM injection
- ❑ Testosterone gel 1% (generic Androgel 1%)
- ❑ Testosterone gel 1% (generic Testim)
- ❑ Testosterone gel 1% (generic Vogelxo)
- ❑ Testosterone gel 1% pump (generic Vogelxo pump)
- ❑ Testosterone gel 2% (generic Fortesta)
- ❑ Testosterone topical solution (generic Axiron)

Select the diagnosis below:

- ❑ Hypogonadism
- ❑ Partial androgen insensitivity syndrome
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have prostate cancer or breast cancer? ❑ **Yes** ❑ **No**

Is the requested medication being used solely for the treatment of sexual dysfunction? ❑ **Yes** ❑ **No**

Hypogonadism, also answer the following:

Is the diagnosis confirmed by two (2) low morning (6AM to 11AM) testosterone levels that were tested within the last 6 months? ❑ **Yes** ❑ **No**

Attach lab results with ranges for both levels

Select if the patient has greater than or equal to <u>one</u> of the following:

- ❑ Incomplete or delayed sexual development
- ❑ Reduced sexual desire (libido) and activity
- ❑ Decreased spontaneous erections
- ❑ Breast discomfort, gynecomastia
- ❑ Loss of body (axillary, facial, and/or pubic) hair
- ❑ Small testes (less than 5 mL) or shrinking testes
- ❑ Low or zero sperm count
- ❑ Height loss, low trauma fracture, or low bone mineral density
- ❑ Hot flushes, sweats

Chart documentation (i.e., chart notes) of the above is required to be submitted along with this fax form

Select if the patient has greater than or equal to <u>two</u> of the following:

- ❑ Decrease energy, motivation, initiative, and self- confidence
- ❑ Depressed mood
- ❑ Poor concentration and memory
- ❑ Sleep disturbance, increased sleepiness
- ❑ Mild anemia (Hgb 10-12)
- ❑ Reduced muscle bulk and strength due to cachexia
- ❑ Increased body fat, BMI
- ❑ Diminished physical or work performance

Chart documentation (i.e., chart notes) of the above is required to be submitted along with this fax form

Partial androgen insensitivity syndrome, also answer the following:

Select if the patient has one of the following:

- ❑ Male gender identity/gender dysphoria
- ❑ Delayed male puberty

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Androgens Prior Authorization Request Form (Page 2 of 2)

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****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ Date: _____

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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.