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

Non-Injectable Testosterone 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 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 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**

Hypogonadism, also answer the following:

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

Attach lab results for both ranges

Select if the patient has greater than or equal to one 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

Select if the patient has greater than or equal to two 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

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Non-Injectable Testosterone Prior Authorization Request Form (Page 2 of 2)

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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

****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.