

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Testosterone cypionate & enanthate (Depo-Testosterone®, Delatestryl®), Buccal Testosterone (Striant®), Testosterone Pellets (Testopel®): Prior Authorization Request Form: Please respond.

- Please complete the attached Testosterone cypionate & enanthate (Depo-Testosterone®, Delatestryl®), Buccal Testosterone (Striant®), Testosterone Pellets (Testopel®) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Testosterone cypionate & enanthate (Depo-Testosterone®, Delatestryl®), Buccal Testosterone (Striant®), Testosterone Pellets (Testopel®)

The use of testosterone in elderly males may place them at an unacceptably high-risk for the development of prostatic hypertrophy, prostatic carcinoma and prostatic hyperplasia. Additionally, these agents have a high potential for overuse, misuse and abuse.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form



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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Testosterone cypionate & enanthate (Depo-Testosterone®, Delatestryl®), Buccal Testosterone (Striant®), Testosterone Pellets (Testopel®) Criteria

- 1 Please indicate testosterone's dispensing location:
 pharmacy
 physician's supply incident to a physician's service
 other: _____
- 2 Please indicate agent requested:
 Testosterone cypionate
 Testosterone enanthate
 Depo-Testosterone®
 Delatestryl®
 Striant®
 Testopel®
- 3 Please indicate the patient diagnosis. Select or specify the correct ICD-9 code. This question must be completed
 Male primary hypogonadism (ICD-9: 256)
 Male hypogonadotropic hypogonadism (ICD-9: 256)
 Female metastatic mammary cancer (ICD-9: 174)
 Delayed Puberty (ICD-9: 259)
 Other (diagnosis and ICD-9 code): _____
- 4 Is the prescribing physician an endocrinologist or oncologist or has one been consulted?
 Yes No
- 5 Does the patient have any of the following conditions? (check any that apply)
 Yes No
 Carcinoma of the breast in men
 Carcinoma of the prostate
 Serious hepatic, cardiac or renal disease
 Pregnancy
- 6 For males: Does the patient have distinctly subnormal testosterone levels (when not treated with testosterone)?
 Yes No
- 7 If Striant and Testopel are requested for the treatment of primary hypogonadism and hypogonadropic hypogonadism, has the patient failed a trial of Depo-Testosterone or Delatestryl first?
 Yes No
 Please note the potential for sleep apnea in obese patients or patients with chronic lung disease. Edema may occur in patients with preexisting cardiac, renal or hepatic disease.

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____