

TESTOSTERONE - TOPICAL ANDROGENS

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: _____

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication **NEW** or a **CONTINUATION of THERAPY** ? If so, start date: _____

Is this patient currently hospitalized? Yes No

SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.
Address:		City: State: Zip:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax Attention to:		

Medication to be Administered: Physician's Office Patient's Home

Deliver Rx to: Physician's Office Other Address: _____
 Patient's Home _____

SECTION C - MEDICAL INFORMATION

Medication:	Strength:
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible):	ICD-9 CODE:

- Is this a new prescription for the patient or a continuation of existing therapy? If this is a continuation of therapy, please provide start date?
- What is the patient's serum testosterone level?
List the serum testosterone level _____ ng/dl
- Has the patient had a documented clinical benefit of topical androgen therapy?
- Have the formulary testosterone products (AndroGel®, Androderm®) failed to treat the patient's condition?

Explanation of why the preferred medication(s) would not meet your patient's needs:

Other Medications tried				
Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician's Signature: _____ **Date:** _____

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