Testosterone

***For treatment of gender dysphoria,** see the Transgender Health Services section of the Physician-Related Services/Health Care Professional Services Billing Guide.

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services| 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Indicate the diagnosis for your patient (check all that apply):
   - ☐ Late-onset (age-related) hypogonadism
   - ☐ HIV-associated weight loss
   - ☐ Male with delayed puberty
   - ☐ Primary hypogonadism
     - Due to: ☐ Bilateral torsion ☐ Cryptorchidism ☐ Chemotherapy
       ☐ Klinefelter Syndrome ☐ Orchiectomy ☐ Orchitis
       ☐ Trauma or toxic damage from alcohol or heavy metals
       ☐ Vanishing testis syndrome
   - ☐ Secondary hypogonadism
     - Select: ☐ Idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency
       ☐ Pituitary hypothalamic injury from tumors, trauma or radiation
   - ☐ Biologic male with severely low testosterone who are symptomatic
   - ☐ Chronic high-dose glucocorticoid therapy
   - ☐ Osteoporosis/low trauma fracture within previous 12 months. Provide T-score:
   - ☐ Biologic female with advancing, inoperable metastatic breast cancer
   - ☐ Other. Specify:
2. Provide your patient's two morning tests (between 8am to 10am) at least one week apart but no more than three months apart, demonstrating low testosterone levels (not applicable for diagnosis of metastatic breast cancer):
   - Total serum testosterone level: ng/dL
   - Free testosterone level: pg/mL
   - Date taken:
   - Total serum testosterone level: ng/dL
   - Free testosterone level: pg/mL
   - Date taken:
3. Provide your patient's follicle stimulating hormone (FSH) and luteinizing hormone (LH) levels at time of diagnosis (not applicable for diagnosis of metastatic breast cancer): FSH: _____ LH: _____
4. If HIV-associated weight loss, provide the following for your patient:
   - Actual body weight:
   - Ideal body weight:
   - Target body weight goal:
   - Describe any changes in their weight during the last 6 months:
5. If chronic high-dose glucocorticoid therapy, provide the following for your patient:
   - Diagnosis requiring glucocorticoid regimen:
   - Current glucocorticoid regimen:
   - Expected duration of treatment:
6. If delayed puberty, indicate the following for your patient:
   - Has patient received a diagnosis of delayed puberty that is NOT secondary to a pathological cause? ☐ Yes ☐ No
   - Has patient's family history of delayed puberty been evaluated to support differential diagnosis of delayed puberty? ☐ Yes ☐ No
   - Has patient responded to "watchful waiting" with reassurance and psychological support in the previous 6 months? ☐ Yes ☐ No
   - Has patient completed puberty? ☐ Yes ☐ No
   - Is patient unable to sustain a normal serum testosterone concentration when not receiving testosterone therapy? ☐ Yes ☐ No
7. If metastatic breast cancer, indicate the following for your patient:
   - Has patient been postmenopausal for 1 to 5 years? ☐ Yes ☐ No
   - Is patient premenopausal and has demonstrated benefit from oophorectomy and has a hormone-responsive tumor? ☐ Yes ☐ No
   - Is this prescribed by, or in consultation with, an oncologist or a prescriber who specializes in treatment of metastatic breast cancer? ☐ Yes ☐ No
   - What first-line metastatic breast cancer treatments have been used?

What were the outcomes?

8. Indicate any of the following for your patient:

Breast cancer or known/suspected prostate cancer	☐ Yes	☐ No
Significant decrease in bone or muscle mass in the last 6 months	☐ Yes	☐ No
Uncontrolled/poorly controlled benign prostate hyperplasia	☐ Yes	☐ No
At higher risk of prostate cancer	☐ Yes	☐ No
Experienced a major cardiovascular event in the past six months	☐ Yes	☐ No
Uncontrolled or poorly-controlled heart failure	☐ Yes	☐ No
Elevated hematocrit (>50%)	☐ Yes	☐ No
Untreated severe obstructive sleep apnea (OSA)	☐ Yes	☐ No
Severe lower urinary tract symptoms	☐ Yes	☐ No
Receiving treatment for osteoporosis or low trauma fracture	☐ Yes	☐ No
Severe adverse events related to testosterone therapy	☐ Yes	☐ No
Pregnant or may become pregnant	☐ Yes	☐ No

Supporting documentation required:
Laboratory and testing results and chart notes documenting diagnosis.

Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)