



Fax completed prior authorization request form to 855-247-3677 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/rbha-forproviders/pharmacy

Testosterone Agents Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information					
Member Name (first & last):	Date of Birth:	Gender:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Member ID:	City:	State:		Weight:	
Prescribing Provider Information					
Provider Name (first & last):	Specialty:	NPI#		DEA#	
Office Address:	City:	State:		Zip Code:	
Office Contact:	Office Phone		Office Fax:		
Dispensing Pharmacy Information					
Pharmacy Name:	Pharmacy Phone:		Pharmacy Fax:		
Requested Medication Information					
Medication Name:					
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one):		ICD-10 Code:		Diagnosis:	
Yes No					
What medication(s) have been tried and failed for diagnosis?					
Are there any contraindications to formulary medications?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify:					
Directions for Use:	Strength:		Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:		
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.			
Signature: _____					
Clinical Information					
<input type="checkbox"/> Testosterone Replacement Therapy					
Are there 2 pre-treatment serum total testosterone levels confirmed on 2 separate mornings with results below the normal range (<264ng/dL or less than reference range for lab)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is there 1 pretreatment free or bioavailable testosterone level (less than reference range for lab)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Does member have a condition that may alter sex-hormone binding globulin (for example obesity, diabetes mellitus, hypothyroidism, etc.)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Are member's initial testosterone concentrations at or near the lower limit of normal?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Does member have ONE of the following diagnosis?	<input type="checkbox"/> Bilateral Orchiectomy	<input type="checkbox"/> Genetic disorder due to hypogonadism (for example, Klinefelter syndrome)	<input type="checkbox"/> Panhypopituitarism		
Was diagnosis of hypogonadism made during or recovery from an acute illness, or when member was engaged in short-term use of certain medications (for example opioids or glucocorticoids)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does member have a diagnosis of Prostate Cancer OR Male Breast Cancer?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Provider will be monitoring the following periodically (check all that apply):	<input type="checkbox"/> Serum testosterone	<input type="checkbox"/> Prostate specific antigen	<input type="checkbox"/> Hemoglobin & hematocrit	<input type="checkbox"/> Liver functions tests	
<input type="checkbox"/> Renewal Request ONLY					
Is testosterone within normal male range?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is hematocrit < 54%?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The following labs are being monitored (check all that apply):		<input type="checkbox"/> PSA		<input type="checkbox"/> Hemoglobin		<input type="checkbox"/> LFTs	
Has member developed prostate cancer OR male breast cancer?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Female to Male Transsexualism							
Was there an evaluation from a mental health professional showing persistent, well-documented diagnosis of gender dysphoria?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did member make a fully informed decision AND has given consent?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the parent and/or guardian consented to treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have co-morbid mental health concerns been OR are actively being addressed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY							
Is testosterone within normal male range?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is hematocrit < 54%?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Delayed Puberty							
Have serial physical evaluations been made over time (6 months or more) to help confirm diagnosis?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Examinations include measurements of the following (check that apply):		<input type="checkbox"/> Height-Weight		<input type="checkbox"/> Tanner stage of pubertal development		<input type="checkbox"/> Bone Age	
		<input type="checkbox"/> Testicular Size					
Are there few to no signs of puberty?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is pubertal delay severe?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
				Are member's psychosocial concerns able to be resolved without treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY							
Measurements of the following continue to be taken (check that apply):		<input type="checkbox"/> Height-Weight		<input type="checkbox"/> Tanner stage of pubertal development		<input type="checkbox"/> Bone Age	
		<input type="checkbox"/> Testicular Size					
Is there still evidence of small testes?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is hematocrit <54%?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Palliative Treatment of Inoperable Breast Cancer in Women							
Is requested medication prescribed by oncologist?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY							
Is member responding to therapy without disease progression?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Acquired Immuno-Deficiency Syndrome - Associated Wasting Syndrome							
Has member been diagnosed with HIV-AIDS?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has member lost at least 10% body weight?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY							
Has member seen and maintained an increase in weight from baseline?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is hematocrit <54%?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records							

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned
Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 800-564-5465 to check the status of a request.