Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Testosterone Products TGC

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Testosterone Products TGC.

Drug Name
(specify drug) ____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: ______________________________
Patient ID: ______________________________
Patient Group No.: ______________________________
Patient DOB: ______________________________
Patient Phone:

Prescribing Physician
Physician Name: ______________________________
Physician Phone: ______________________________
Physician Fax: ______________________________
Physician Address: ______________________________
City, State, Zip: ______________________________

Diagnosis: ______________________ **ICD Code:** ______________________

Comments: ____

Please circle the appropriate answer for each question.	
1. Is the requested drug being prescribed for primary or hypogonadotropic hypogonadism?	Y N
[Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]	
[If no, then skip to question 5.]	
2. Is this request for a continuation of testosterone therapy?	Y N
[If no, then skip to question 4.]	
3. Before the patient started testosterone therapy, did the patient have a confirmed low testosterone level according	Y N

	to current practice guidelines or your standard male lab reference values?	
	[No further questions.]	
4.	Does the patient have at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values?	Y N
	[No further questions.]	
5.	Is Delatestryl (testosterone enanthate injection) being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal AND has the patient had an incomplete response to other therapy for metastatic breast cancer?	Y N
	[If yes, then no further questions.]	
6.	Is Delatestryl (testosterone enanthate injection) being prescribed for a pre-menopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor?	Y N
	[If yes, then no further questions.]	
7.	Is Delatestryl (testosterone enanthate injection) or Testopel (testosterone propionate implant pellets) being prescribed for delayed puberty?	Y N
	[If yes, then no further questions.]	
8.	Is the requested drug being prescribed for female-to-male gender reassignment in a patient who is 14 years of age or older and able to make an informed, mature decision to engage in therapy?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date