Prior Authorization Form

Testosterone Oral Products

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 Oral Products.

Drug Name (select from list of drugs shown)

Android (methyltestosterone)	Androxy (fluoxymesterone)	Fluoxymesterone
Methitest (methyltestosterone)	Methyltestosterone	Testred (methyltestosterone)

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. Has the patient tried and failed or is the patient unable to tolerate one non-oral form of testosterone supplementation?	Y N
2. Is the drug being prescribed for inoperable metastatic breast cancer in a female 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.]	
3. Is the drug being prescribed for a pre-menopausal female 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.]	
4. Is the drug being prescribed for a male patient with congenital or acquired primary hypogonadism (i.e., testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy)?	Y N
[If yes, then skip to question 6.]	
5. Is the drug being prescribed for a male patient with congenital or acquired hypogonadotropic hypogonadism (i.e., gonadotropin or luteinizing hormone-releasing hormone [LHRH] deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation)?	Y N
[If no, then skip to question 7.]	
6. Did the patient have or does the patient have at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values?	Y N
[No further questions.]	
7. Is the drug being prescribed for delayed puberty in a male patient?	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