

UPMC HEALTH PLAN

TESTOSTERONE Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:			
Provider First Name:		Provider Last Name:			
Provider Phone:		Provider Fax:		Provider NPI #:	
Patient Name:		Patient UPMC Health Plan ID Number:		Patient DOB:	Patient Age:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic		Strength:	Frequency:	Qty Dispensed:	
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>					
<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?		<input type="checkbox"/> Yes	
<input type="checkbox"/> Ongoing medication				<input type="checkbox"/> No	
TOTAL testosterone level lab range when OFF THERAPY in ng/dl ⁸ (please specify units and type of testosterone):		Date:	Patient Height:	Patient Weight:	
Please indicate place of administration?		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Facility		Please indicate how medication will be billed:	
Please provide facility/provider name and address:		<input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____			
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider			
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient			
Diagnosis (Please Check One):					
<input type="checkbox"/> Primary Hypogonadism (congenital or acquired) IF SO INDICATE CONDITION BELOW: <ul style="list-style-type: none"> <input type="checkbox"/> Testicular failure due to cryptorchidism <input type="checkbox"/> Orchidectomy <input type="checkbox"/> Vanishing testis syndrome <input type="checkbox"/> Bilateral torsions <input type="checkbox"/> Orchitis 					
<input type="checkbox"/> Hypogonadotropic hypogonadism (congenital or acquired) - idiopathic gonadotropin or LHRH deficiency, or pituitary- hypothalamic injury from tumors, trauma or radiation.					
<input type="checkbox"/> Other (please be specific):					
Please provide any additional information which should be considered in the space below:					