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: ☐**Brand** ☐**Generic**	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐**New medication** ☐**Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did the member show improvement while on therapy?**	☐**Yes** ☐**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? ☐Physician's Office ☐Hospital/Facility **Please provide facility/provider name and address:**	**Please indicate how medication will be billed:** ☐ Billed directly by the provider via JCODE Provide JCODE:______________________ ☐ Billed by a pharmacy and delivered to the provider ☐ Billed by a pharmacy and delivered to the patient

Diagnosis *(Please Check One)*:

☐ **Primary Hypogonadism (congenital or acquired) IF SO INDICATE CONDITION BELOW:**
- ☐**Testicular failure due to cryptorchidism**
- ☐**Orchidectomy**
- ☐**Vanishing testis syndrome**
- ☐**Bilateral torsions**
- ☐**Orchitis**

☐ **Hypogonadotrophic Hypogonadism (congenital or acquired) - idiopathic gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation.**

☐ **Other *(please be specific)*:**

Has the member previously tried and failed Androgel 1.62%? ☐ Yes ☐**No**

Previous Therapy	**Dates of Therapy**		**Strength**	**Frequency**	**List Adverse Reactions/side Effects/ Reason for Discontinuing**
	Start Date	**End Date**			

Please provide any additional information which should be considered in the space below: