EXPRESS SCRIPTS®

Prior Authorization Form
Topical Testosterone

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-800-357-9577**
If this an **URGENT** request, please call 1-800-417-8164

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Androderm 2.5mg/24hr Transdermal System
- ☐ Androderm 5mg/24hr Transdermal System
- ☐ Androgel 1% Metered Dose Pump Transdermal Gel
- ☐ Androgel 1.62% Metered Dose Pump Transdermal Gel
- ☐ Androgel 1% Transdermal Gel
- ☐ Axiron 30mg/actuation Topical Solution
- ☐ First-Testosterone 2% Compounding Kit
- ☐ First-Testosterone MC 2% Compounding Kit
- ☐ Fortesta 10mg/actuation Transdermal Gel
- ☐ Striant 30mg Buccal System
- ☐ Testim 1% Topical Gel
- ☐ Other: _____

Directions for use (i.e. QD, BID, PRN & Qty):_____

Please complete the clinical assessment:			
1. Does the patient have hypogonadism (primary or secondary) as confirmed by a low for age pre-treatment serum testosterone (total or free) level defined by the normal laboratory reference values?	☐ Yes	☐ No	☐ N/A
2. Is the requested medication going to be used to enhance athletic performance?	☐ Yes	☐ No	☐ N/A
3. Is the requested medication being prescribed by, or in consultation with, an endocrinologist?	☐ Yes	☐ No	☐ N/A
4. Does the patient have carcinoma of the breast OR known or suspected carcinoma of the prostate?	☐ Yes	☐ No	☐ N/A
5. Is the patient 14 years of age or older AND the medication is being requested for the treatment of delayed puberty or induction of puberty?	☐ Yes	☐ No	☐ N/A

6. Is the requested medication being used for female-to-male (FTM) gender reassignment (endocrinologic masculinization)?	☐ Yes	☐ No	☐ N/A
7. Has the patient tried any of the following medications? __Androderm __Striant __AndroGel __Testim __Axiron __First-Testosterone MC __Fortesta __First-Testosterone	☐ Yes	☐ No	☐ N/A

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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