

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**



**Androgens  
Prior Authorization of Benefits (PAB) Form**

Complete form in its entirety and fax to:  
Prior Authorization of Benefits Center at (800) 601- 4829

**1. PATIENT INFORMATION**

**2. PHYSICIAN INFORMATION**

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

**3. MEDICATION**

**4. STRENGTH**

**5. DIRECTIONS**

**6. QUANTITY PER 30 DAYS**

<input type="checkbox"/> Androderm <input type="checkbox"/> AndroGel <input type="checkbox"/> AndroGel Metered Dose Pump <input type="checkbox"/> Testim <input type="checkbox"/> Striant <input type="checkbox"/> Testosterone Propionate <input type="checkbox"/> Testosterone Powder for compounding <input type="checkbox"/> Depo-Testosterone (testosterone cypionate) <input type="checkbox"/> Delatestryl (testosterone enanthate)	<input type="checkbox"/> 2.5mg/24hr <input type="checkbox"/> 5mg/24hr <input type="checkbox"/> 1% <input type="checkbox"/> 75g pump <input type="checkbox"/> 1% <input type="checkbox"/> 30mg <input type="checkbox"/> 100mg/mL <input type="checkbox"/> _____ <input type="checkbox"/> 100mg/mL <input type="checkbox"/> 200mg/mL <input type="checkbox"/> 200mg/mL	_____ _____ _____	Specify: _____
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**7. DIAGNOSIS:** \_\_\_\_\_

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient is male
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has had an orchiectomy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	The diagnosis is hypogonadism or testicular hypofunction
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has a diagnosis <b>other</b> than hypogonadism or testicular hypofunction and the Reference Laboratory Range is: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient is beginning treatment with topical testosterone; if yes, MUST provide testosterone level here: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient is continuing successful treatment
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient is female
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes</b> , patient has a diagnosis of metastatic breast cancer
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has delayed male puberty
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medication will be used for treatment of weight loss in an AIDS patient with HIV-associated wasting
<i>Requests for increased quantities of AndroGel packets 2.5gm, AndroGel packets 5gm, or Testim packets 5gm:</i>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	The patient has been using this product for the previous 14 days prior to this request.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, is the testosterone level still below the reference range?

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PATIENT NAME: \_\_\_\_\_ PATIENT ID #: \_\_\_\_\_

9. PHYSICIAN SIGNATURE

Prescriber or Authorized Signature \_\_\_\_\_

Date \_\_\_\_\_

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message by error, please notify us immediately at (800) 338-6180 and destroy the related message or return the document to us at 8407 Fallbrook Avenue AF13, West Hills, CA 91304. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.