Androgen Preauthorization Physician Fax Form

Only the prescriber may complete this form for prospective reviews.
The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Start saving time by filling out this preauthorization electronically at* MedicalPolicy.NebraskaBlue.com.

What is the priority level of this request?

☐ Standard review - Completed within 15 calendar days of receipt.

☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Today's Date: _____

Patient Information

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):	Telephone Number:

Insurance Information

BCBS ID Number:

Physician/Clinic Information

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip Code:		Phone Number:		Secure Fax Number:

Preauthorization Information

Medication Requested: _____

Medication Dose Requested: _____

Diagnosis: _____

Height: _____ **Weight:** _____ **Gender:** _____

1. Is the patient currently being treated with testosterone replacement therapy?..... ☐ Yes ☐ No
   A. Is the patient currently being treated with the requested medication?..... ☐ Yes ☐ No
2. Has the patient tried and failed Axiron and Androgel?..... ☐ Yes ☐ No
3. Is checking testosterone levels medically appropriate for this patient's gender?..... ☐ Yes ☐ No
4. What is the requested medication being used to treat?

☐ Hypogonadism (low testosterone)

A. What are the patient symptoms of androgen deficiency? _____

B. What is the pre-treatment/baseline serum testosterone level (provide documentation)? _____

☐ Palliative treatment of metastatic inoperable breast cancer

☐ AIDS/HIV-associated wasting syndrome, defined as unexplained involuntary weight loss (>10% baseline body weight) with obvious wasting OR body mass index <18.5 kg/m2 AND all other causes of weight loss have been ruled out

☐ Adolescent with delayed puberty

☐ Anemia caused by deficient red cell production, including acquired aplastic anemia, congenital aplastic anemia, myelofibrosis and the hypoplastic anemias due to the administration of myelotoxic drugs

☐ Anemia associated with chronic renal failure AND either the patient has previously used an erythropoiesis-stimulating agent OR he/she has a documented intolerance, FDA labeled contraindication or hypersensitivity to an ESA (please provide documentation)

☐ Other (provide description and documentation) _____

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5. Will the patient be treated with more than one androgen therapy?..... ☐ Yes ☐ No

6. If this is a renewal, describe any improvement in symptoms and include pertinent documentation:

_____

_____

7. Please list clinical information that should be included in this review:

_____

_____

Please fax additional information with this form if necessary and pertinent to this review.

Please fax or mail this form to:
Prime Therapeutics
Pharmacy Department - UM
PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726
Phone: 877-999-2374

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