



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 primary hypogonadism (congenital or acquired)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
2. Is the requested medication going to be used to enhance athletic performance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
3. Does the patient have secondary (hypogonadotropic) hypogonadism (congenital or acquired)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
4. Is the requested medication being prescribed by, or in consultation with, an endocrinologist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
5. Does the patient have carcinoma of the breast OR known or suspected carcinoma of the prostate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

6. Is the patient 12 years of age or older AND the medication is being requested for the treatment of delayed puberty or induction of puberty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
7. Is the requested medication being used for female-to-male (FTM) gender reassignment (endocrinologic masculinization)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
8. Has the patient tried any of the following medications? ___Androderm ___Striant ___AndroGel ___Testim ___Axiron ___First-Testosterone MC ___Fortesta ___First-Testosterone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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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