CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Testosterone**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

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:	CCHP Member ID #:	Patient DOB:	Patient Age:

Drug Requested:	Strength:	Frequency:	Quantity Dispensed (including units):

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

New medication **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	**Yes** **No**

TOTAL testosterone level lab range when OFF THERAPY in ng/dl8 *(please specify units and type of testosterone):*	Date:	Height:	Weight:

Diagnosis:	**Date of diagnosis:**

Please indicate place of administration:

Physician's Office **Hospital/Facility**

Please provide hospital/facility information:

Name: ______________________________

Phone #: ______________________________

Address: ______________________________

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Will the drug be: (select one)

Billed directly by the provider via JCODE

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	Start Date	End Date	Strength	Frequency	List adverse reactions/side effects/

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