



2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Topical Testosterone Products - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields: Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, Specialty/facility name (if applicable).

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields: Drug Name, Strength, Directions / SIG

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.

Q1. Is the request for continuation of therapy?
Q2. Is the patient 18 years of age or older?
Q3. Is the medication being used for a diagnosis of hypogonadism?
Q4. Is the medication being used for a medically accepted indication not otherwise excluded from Part D? Please provide documentation of diagnosis.
Q5. Do labs show low testosterone levels in comparison to lab reference values on 2 separate occasions (include labs)?
Q6. Does the patient experience symptoms as a result of testosterone deficiency (include explanation of symptoms)?

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Patient Name:	Prescriber Name:
Q7. Does the patient have any contraindications to testosterone therapy including the following: carcinoma of the breast, known or suspected prostate cancer, pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Has the patient's response to testosterone therapy been evaluated? Please provide documentation of the patient's response to therapy. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Requested Duration: <input type="checkbox"/> 12 months <input type="checkbox"/> Other	
Q10. Additional Information:	

Prescriber Signature

Date

2024 Medicare Prior Authorization Request