

Pharmacy

PRIOR AUTHORIZATION FORM

Last Reviewed: January 2012

Last Updated: January 2010

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Testim[®] (testosterone)

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

Testim 1% Topical Gel

Start Date: _____

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Testim[®] (testosterone) requires the following information to certify:

Patient must have met the following requirements:

- Laboratory confirmed low testosterone level (**lab report must be submitted with this request**)
- Age 18 years or older
- Male gender
- Patient must **not** have a history of prostate or breast cancer

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Testim[®] (testosterone) requires the following information to certify:

A. Does the patient have laboratory confirmed low testosterone levels?a. Yesb. No – Rationale for use: _____**B. A copy of the lab report is attached to this request.****C. Does the patient have a history of prostate cancer?** No Yes – Rationale for use: _____**D. Does the patient have a history of breast cancer?** No Yes – Rationale for use: _____

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

***** All fields must be complete and legible for Prior Authorization Review*****

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX