BlueCross BlueShield Federal Employee Program

TESTOSTERONE – INJECTION / IMPLANT PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER COMPLETES

Cardholder Name: _____ / _____ / _____
First MI Last

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F ____ **R** [| | | | | | | | |]
Cardholder Identification Number

PHYSICIAN COMPLETES

Testosterone – Injection & Implant (Please choose the product being requested)		
❑Aveed* ⇨_____ per 90 days	❑Depo-Testosterone 100mg/ml ⇨_____ per 90 days	❑Testopel Pellet ⇨_____ per 90 days
❑Delatestryl ⇨_____ per 90 days	❑Depo-Testosterone 200mg/ml ⇨_____ per 90 days	❑Testone CIK ⇨_____ kits per 90 days

*For requests for Aveed, has the prescriber been certified by the Aveed REMS program? ❑Yes ❑No ❑N/A

1. Will the patient be using this medication in combination with any other form of testosterone? ❑Yes ❑No

Section A – Complete for FEMALE patients

1. What is the patient's diagnosis?
   ❑Inoperable metastatic breast cancer ❑Inoperable metastatic mammary cancer ❑Other *(please specify):* _____
2. If initiating testosterone therapy, has the patient received at least one prior therapy for treatment of this condition? ❑Yes ❑No
3. Will the patient be monitored for hypercalcemia every 6 months and be advised to discontinue testosterone if found to be present? ❑Yes ❑No
4. Will the liver function tests and hematocrit level be monitored every 6 months? ❑Yes ❑No

Section B – Complete for MALE patients 12 YEARS OF AGE OR OLDER

1. What is the patient's diagnosis? **❑Delay in sexual development and/or puberty ❑Other *(please specify):*** _____
2. Will the patient's bone age of the hand and wrist be assessed every 6 months as determined by radiographic evidence? ❑Yes ❑No
3. Will the liver function tests and hematocrit level be monitored every 6 months? ❑Yes ❑No

Section C – Complete for MALE patients 18 YEARS OF AGE OR OLDER

1. What is the patient's diagnosis? **❑Deficiency of testosterone/hypogonadism ❑Other *(please specify):*** _____
2. Is this the **INITIATION** or **CONTINUATION** of testosterone therapy?

❑This is the **INITIATION** of testosterone therapy ***(please answer the following questions)***

a. Has the patient had two morning total testosterone levels less than 300 ng/dL on different days? ❑Yes ❑No
b. What percent is the patient's hematocrit level? _____%
c. **For patients >40 years of age**: Does the patient have a baseline PSA level less than 4 ng/ml? ❑Yes ❑No ❑N/A – patient had a prostatectomy
d. Does the patient have current diagnosis of prostate cancer and/or palpable prostate nodules? ❑Yes ❑No
e. Does the patient have a concurrent diagnosis of benign prostate hyperplasia (BPH)? ❑Yes* ❑No
   ***If YES**, will the symptoms associated with BPH be monitored for worsening symptoms? ❑Yes ❑No
f. Has the patient had an evaluation of their cardiovascular risk for MI, angina, and stroke? ❑Yes ❑No ❑Unknown
g. Does the patient have a diagnosis of sleep apnea? ❑Yes* ❑No ❑Unknown
   ***If YES**, is the patient being treated for their sleep apnea? ❑Yes ❑No ❑Unknown

❑This is the **CONTINUATION** of testosterone therapy ***(please answer the following questions)***

a. Does the patient have a total testosterone level 800 ng/dL or less? ❑Yes ❑No
b. If the patient has BPH, have the patient's symptoms worsened? ❑Yes ❑No ❑N/A – patient does not have BPH
c. Will the following be monitored every 12 months:
   - Serum testosterone concentrations ❑Yes ❑No
   - Hematocrit levels ❑Yes ❑No
   - **For patients >40 years of age**: Prostate specific antigen (PSA) ❑Yes ❑No ❑N/A – patient had a prostatectomy

d. Has the patient been re-evaluated for their cardiovascular risk for MI, angina, and stroke? ❑Yes ❑No ❑Unknown

Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

_____ (_____) _____ (_____) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____ / _____ / _____
Prescriber's NPI Physician Signature Date

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically (ePA) (2-3 **minutes**)	Phone (4-5 **minutes** for response)	Fax (3-5 **days** for response)
Now you can get responses to drug prior authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Submissions may be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA.	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same info contained on the attached form. The process over the phone takes on average between 4 and 5 minutes.	Fax the attached form to (877)-378-4727 Requests sent via fax will be processed and responded to within 5 business days. ***Please only fax the completed form once as duplicate submissions may delay processing times.***