

# Testosterone Replacement Prior Authorization Form

**START HERE**

**Member &  
Prescriber  
Information**

Member Name:	Prescriber Name:
	Prescriber Specialty:
Member Date of Birth:	Prescriber Phone #:
Member ID #:	Prescriber Fax #:

**Criteria**

Must have two laboratory-confirmed low free testosterone tests **plus** 3 or more symptoms suggestive of androgen deficiency

Provide copies of laboratory reports showing date and time stamp of testing also recorded on form.

Washout period may be required to fulfill criteria if patient is already on therapy without labs.

Higher dosages not approvable when testosterone levels within normal range.

**Diagnosis:**

**Symptoms (at least 3 total symptoms required)**

At least two symptoms from this list		One symptom from this list
<input type="checkbox"/> eunuchoidism, aspermia	<input type="checkbox"/> height loss, bone loss	<input type="checkbox"/> diminished work performance
<input type="checkbox"/> loss of body hair	<input type="checkbox"/> low-trauma fracture	<input type="checkbox"/> decreased libido
<input type="checkbox"/> muscle loss, weakness	<input type="checkbox"/> memory loss	<input type="checkbox"/> erectile dysfunction
<input type="checkbox"/> hot flashes, sweats	<input type="checkbox"/> mild anemia	<input type="checkbox"/> low energy, motivation
<input type="checkbox"/> breast discomfort	<input type="checkbox"/> small/shrinking testes	<input type="checkbox"/> depressed mood

**Patient new to testosterone replacement therapy**

AM Free Testosterone Level #1		AM Free Testosterone Level #2	
Date/Time	Level (ref. range)	Date/Time	Level (ref. range)

**Patient continuing or switching testosterone therapy**

Current Testosterone Regimen:

AM Pretreatment Free Level (date/time):	AM Posttreatment Free Level (date/time):

**Choose  
Product**

- Androgel** 1% 150 gram pump (this is the lower cost option compared to the 2.5g packets)
- Androgel** 1% 2.5 gram packets
- Androderm** 2.5 mg/24 hours patches
- Androgel** 1% 5 gram packets
- Testim** 1% 50 gram gel
- Androderm** 5 mg/24 hours patches
- Other:** \_\_\_\_\_

**Sign/Date &  
Mail or Fax**

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber NPI: \_\_\_\_\_

**Mailing Address**

Physicians Plus Insurance Corporation  
Attn: Pharmacy Services  
P.O. Box 2078  
Madison WI 53701-2078

**Physicians Plus Pharmacy Services Fax:**

(608) 258-1905

**Prior Authorization Questions?**

(608) 260-7803 or (800) 545-5015 (ext. 7803)

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