Prior Authorization Form

Delatestryl

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Delatestryl.

Drug Name (select from list of drugs shown)

Testosterone enanthate Xyosted (testosterone enanthate)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for primary or hypogonadotropic hypogonadism? Y N

[Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]

[If no, then skip to question 5.]

2. Is this request for a continuation of testosterone therapy? Y N

[If no, then skip to question 4.]

3. Before the patient started testosterone therapy, did the patient have a confirmed low morning testosterone level Y N

	according to current practice guidelines or your standard lab reference values?	
	[No further questions.]	
4.	Does the patient have at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values?	Y N
	[No further questions.]	
5.	Is this a request for testosterone enanthate injection (generic Delatestryl)?	Y N
	[If no, then no further questions.]	
6.	Is the requested drug being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal AND has the patient had an incomplete response to other therapy for metastatic breast cancer?	Y N
	[If yes, then no further questions.]	
7.	Is the requested drug being prescribed for a premenopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor?	Y N
	[If yes, then no further questions.]	
8.	Is the requested drug being prescribed for delayed puberty?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date