Prior Authorization Form

Depo-Testosterone

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 Depo-Testosterone.

Drug Name (select from list of drugs shown)

Depo-Testosterone (testosterone cypionate) Testosterone Cypionate Injection

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 drug being prescribed for a male patient with congenital or acquired primary Y N

hypogonadism (i.e., testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy)?	
[If yes, then skip to question 3.]	
2. Is the drug being prescribed for a male patient with congenital or acquired hypogonadotropic hypogonadism (i.e., gonadotropin or luteinizing hormone-releasing hormone [LHRH] deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation)?	Y N
3. Did the patient have or does the patient have at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date