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## CAREFIRST Testosterone Products GR

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Testosterone Products GR.

<b>Patient Name:</b>	_____	<b>Date:</b>	3/31/2025
<b>Patient ID:</b>	_____	<b>Patient Date Of Birth:</b>	_____
<b>Patient Group No:</b>	_____	<b>Patient Phone:</b>	_____
	<b>NPI#:</b>		<b>Physician Name:</b>
			<b>Specialty:</b>
			<b>Physician Office Telephone:</b>
<b>Physician Office Address:</b>	_____		
	_____		
<b>Drug Name (specify drug)</b>	_____		
<b>Quantity:</b>	_____	<b>Frequency:</b>	_____
		<b>Strength:</b>	_____
<b>Route of Administration:</b>	_____	<b>Expected Length of Therapy:</b>	_____
<b>Diagnosis:</b>	_____	<b>ICD Code:</b>	_____
<b>Comments:</b>	_____		
	_____		
	_____		

### Please check the appropriate answer for each applicable question.

- |     |  |                            |                            |
|-----|--|----------------------------|----------------------------|
| 1.  | Is the requested drug being prescribed for age-related hypogonadism (also referred to as late-onset hypogonadism)?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 2.  | Is the requested drug being prescribed for primary or hypogonadotropic hypogonadism?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 3.  | Is this request for continuation of therapy?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 4.  | Before the patient started testosterone therapy, did the patient have a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 5.  | Does the patient have at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values, before the start of testosterone therapy?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 6.  | Is the requested drug being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy?  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 7.  | Are the patient's comorbid conditions reasonably controlled?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 8.  | Has the patient been educated on ANY contraindications AND side effects to therapy?  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 9.  | Is the patient less than 18 years of age?  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 10. | Is the requested drug being prescribed by, or in consultation with, a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist), that has collaborated care with a mental health provider? | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 11. | Has the patient reached, or previously reached, Tanner stage 2 of puberty or greater?  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 12. | Is the patient new to testosterone therapy?  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 13. | Has the patient been informed of fertility preservation options?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 14. | Is this request for testosterone propionate implant pellets (Testopel)?  | Y <input type="checkbox"/> | N <input type="checkbox"/> |



- |     |  |   |                          |   |                          |
|-----|--|---|--------------------------|---|--------------------------|
| 15. | Is this request for intramuscular testosterone enanthate injection (generic Delatestryl)?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 16. | Is the requested drug being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal and had an incomplete response to other therapy for metastatic breast cancer? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 17. | Is the requested drug being prescribed for a pre-menopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor?                             | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 18. | Is the requested drug being prescribed for delayed puberty?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

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.

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**Prescriber (Or Authorized) Signature and Date**

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