PA Request Criteria

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CAREFIRST - MD EXCHANGE 5T

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 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 11/28/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
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Drug Name (select from list of drugs shown)
Methyltestosterone

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____

Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1.	Has the patient experienced an inadequate treatment response to an alternative testosterone product (e.g., topical testosterone, transdermal testosterone, injectable testosterone)?	**Y** ☐	**N** ☐
2.	Has the patient experienced an intolerance to an alternative testosterone product (e.g., topical testosterone, transdermal testosterone, injectable testosterone)?	**Y** ☐	**N** ☐
3.	Does the patient have a contraindication that would prohibit a trial of alternative testosterone products (e.g., topical testosterone, transdermal testosterone, injectable testosterone)?	**Y** ☐	**N** ☐
4.	Is the requested drug being prescribed for age-related hypogonadism?	**Y** ☐	**N** ☐
5.	Is the requested drug being prescribed for primary or hypogonadotropic hypogonadism?	**Y** ☐	**N** ☐
6.	Is this request for a continuation of testosterone therapy?	**Y** ☐	**N** ☐
7.	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** ☐	**N** ☐
8.	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** ☐
9.	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** ☐
10.	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** ☐
11.	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.

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Prescriber (Or Authorized) Signature and Date

Effective July 1, 2015, Maryland law will require providers to submit pharmaceutical preauthorization requests electronically. To use ePA, either contact your electronic health record vendor or visit www.covermymeds.com/epa/caremark