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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 Telephone:** \_\_\_\_\_  
**Physician Office Address:** \_\_\_\_\_

**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 <input type="checkbox"/> | N <input type="checkbox"/> |
| 2. Has the patient experienced an intolerance to an alternative testosterone product (e.g., topical testosterone, transdermal testosterone, injectable testosterone)?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 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 <input type="checkbox"/> | N <input type="checkbox"/> |
| 4. Is the requested drug being prescribed for age-related hypogonadism?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 5. Is the requested drug being prescribed for primary or hypogonadotropic hypogonadism?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 6. Is this request for a continuation of testosterone therapy?  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 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 <input type="checkbox"/> | N <input type="checkbox"/> |
| 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 <input type="checkbox"/> | N <input type="checkbox"/> |
| 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 <input type="checkbox"/> | N <input type="checkbox"/> |
| 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 <input type="checkbox"/> | N <input type="checkbox"/> |
| 11. 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.

**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](http://www.covermymeds.com/epa/caremark)