BlueCross BlueShield Federal Employee Program

TESTOSTERONE POWDER PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please choose the dosage form being requested for compounding:

❑Injectable ❑Nasal Spray ❑Oral (capsule/suspension/tablet) ❑Topical (cream/gel/ointment/patch/solution)

❑Other dosage form *(please specify)*: _____

What is the final dose/strength being requested? _____

This form is for COMPOUNDING the medication only, not for the commercially available products.

1. Is the requested dosage form commercially available? ❑Yes ❑No
2. Has the patient tried and failed a commercially available product (injectable, nasal spray, oral, topical, etc)? ❑Yes ❑No
3. Does the patient have an intolerance to the inactive ingredient(s) in the commercially available product? ❑Yes ❑No
4. Has the patient tried and failed a commercially available product in a different dosage form? ❑Yes ❑No
5. Does the requested dose/strength equal to or exceed the FDA-approved dose/strength for the requested dosage form? ❑Yes ❑No

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Will this medication be used in combination with another form of testosterone other than the compounded form being requested? ❑Yes***** ❑No ❑Patient is changing to the requested dosage form

   ****If YES***, specify the medication: _____

2. Is the patient being treated for gender dysphoria (GD), gender identity disorder (GID), sex transformation, or sex change? ***Answer below:***

   ❑**YES**: Is the patient undergoing a female to male transition? ❑Yes ❑No

   ❑**NO**: Please answer the following questions:

   a. What is the patient's diagnosis?

   ❑Delay in sexual development and/or puberty

   i. Will the patient's bone age of the hand and wrist be assessed every 6 months as determined by radiographic evidence? ❑Yes ❑No

   ii. Will the patient's liver functions tests be monitored every 6 months? ❑Yes ❑No

   iii. Will the patient's hematocrit levels be monitored every 6 months? ❑Yes ❑No

   iv. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc) continuously for the last **4 months** excluding samples? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

TESTOSTERONE POWDER PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Inoperable metastatic breast cancer **OR** ❑Inoperable metastatic mammary cancer

i. Has the patient received at least one prior therapy for treatment of this condition? ❑Yes ❑No

ii. Will the patient be monitored for hypercalcemia every 6 months and be advised to discontinue testosterone if found to be present? ❑Yes ❑No

iii. Will the patient's liver functions tests be monitored every 6 months? ❑Yes ❑No

iv. Will the patient's hematocrit levels be monitored every 6 months? ❑Yes ❑No

v. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc) continuously for the last **4 months** excluding samples? ❑Yes ❑No

❑Deficiency of testosterone **OR** ❑Hypogonadism **OR** ❑Low testosterone (Low T) **OR**
❑Testicular hypofunction **OR** ❑Androgen deficiency

i. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc) continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

1) Has the patient had two morning total testosterone levels less than 300 ng/dL on different days? ❑Yes ❑No

2) What is the patient's hematocrit? _____ %

3) Does the patient have a current diagnosis of prostate cancer? ❑Yes ❑No*****

****If NO***, does the patient have palpable prostate nodules? ❑Yes ❑No

4) Has the patient had a prostatectomy? ❑Yes ❑No*****

****If NO***, please answer the following questions:

a) What is the patient's baseline prostate specific antigen (PSA)? _____ng/mL ❑PSA not tested

b) **If PSA less than 4ng/mL**: Does the patient have a concurrent diagnosis of benign prostate hyperplasia (BPH)? ❑Yes***** ❑No

****If YES***, will the patient be monitored for worsening symptoms of BPH? ❑Yes ❑No

5) Does the patient have a diagnosis of sleep apnea? ❑Yes***** ❑No

****If YES***, is the patient being treated for their sleep apnea? ❑Yes ❑No

6) Has the prescriber assessed the patient for their cardiovascular risk for myocardial infarction (MI), angina, or stroke? ❑Yes ❑No

❑**YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

1) Does the patient have a total testosterone level of 800 ng/dL or less? ❑Yes ❑No

2) Has the patient had a prostatectomy? ❑Yes ❑No*****

****If NO,*** please answer the following questions:

a) Does the patient have a concurrent diagnosis of benign prostate hyperplasia (BPH)? ❑Yes***** ❑No

****If YES***, have the symptoms associated with BPH worsened since beginning testosterone therapy? ❑Yes ❑No

b) Will the patient's prostate specific antigen (PSA) level be tested every 12 months? ❑Yes ❑No

3) Will the patient's serum testosterone concentrations be monitored every 12 months? ❑Yes ❑No

4) Will the patient's hematocrit levels be monitored every 12 months? ❑Yes ❑No

5) Has the prescriber re-assessed the patient for their cardiovascular risk for myocardial infarction (MI), angina, or stroke? ❑Yes ❑No

❑Other ***(please specify):*** _____