BlueCross BlueShield Federal Employee Program

TESTOSTERONE TOPICAL 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					

Testosterone Topical

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

Please select topical product, strength(s), and provide quantity being requested for 90 days:

Androderm patch **❑2mg quantity _____ every 90 days** **❑4mg quantity _____ every 90 days**	**Fortesta pump** **❑120 pump/60gm quantity _____ every 90 days**
AndroGel 1% packet/pump **❑2.5gm quantity _____ every 90 days** **❑5gm quantity _____ every 90 days** **❑Pump quantity _____ every 90 days**	**❑Testim tube quantity _____ every 90 days**
AndroGel 1.62% packet/pump **❑1.25gm quantity _____ every 90 days** **❑2.5gm quantity _____ every 90 days** **❑Pump quantity _____ every 90 days**	**Vogelxo bottle/packet/tube** **❑1% (1.25mg) bottle quantity _____ every 90 days** **❑1% (50mg) packet quantity _____ every 90 days** **❑1% (50mg) tube quantity _____ every 90 days**
Axiron 30mg/1.5mL solution **❑60 pumps per 90ml quantity _____ every 90 days**	

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

Is this request for brand or generic? ❑Brand ❑Generic

1. Will this medication be used in combination with any other form of testosterone? ❑Yes* ❑No
   If YES, please 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. Is the patient assigned female or male at birth? ❑Male ❑Female
   b. What is the patient's diagnosis?
   ❑Deficiency of testosterone ❑Androgen deficiency ❑Hypogonadism ❑Low testosterone (Low T)
   ❑Testicular hypofunction
   ❑Other ***(please specify):*** _____

PLEASE PROCEED TO PAGE 2 FOR DEFICIENCY OF TESTOSTERONE, ANDROGEN DEFICIENCY, HYPOGONDADISM, LOW T, OR TESTICULAR HYPOFUNCTION DIAGNOSIS

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PAGE 2 - PHYSICIAN COMPLETES

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

c. 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 the answer below:***

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

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

ii. What is the patient's hematocrit? _____ % ❑Hematocrit was not tested

iii. Does the patient have a current diagnosis of prostate cancer? ❑Yes ❑No

iv. Does the patient have palpable prostate nodules? ❑Yes ❑No

v. Has the patient had a prostatectomy? ❑Yes ❑No*****

If NO**, does the patient have a baseline prostate specific antigen (PSA) which is less than 4 ng/ml? ***Answer below:
❑Yes ❑No ❑PSA was not tested

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

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

vii. Does the patient have a diagnosis of sleep apnea? ❑Yes***** ❑No

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

viii. 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:

i. Does the patient have a total testosterone level 800 ng/dL or less? ❑Yes ❑No

ii. Has the patient had a prostatectomy? ❑Yes ❑No

iii. Does the patient have a concurrent diagnosis of benign prostatic hyperplasia (BPH)? ❑Yes ❑No

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

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

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

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

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