Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Methyltestosterone

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Has the patient experienced an inadequate treatment response to an alternative testosterone product (e.g., topical testosterone, transdermal testosterone, injectable testosterone)?

☐ Yes ☐ No

Q2. Has the patient experienced an intolerance to an alternative testosterone product (e.g., topical testosterone, transdermal testosterone, injectable testosterone)?

☐ Yes ☐ No

Q3. Does the patient have a contraindication that would prohibit a trial of alternative testosterone products (e.g., topical testosterone, transdermal testosterone, injectable testosterone)?

☐ Yes ☐ No

Q4. Is the requested drug being prescribed for age-related hypogonadism?

☐ Yes ☐ No

Q5. Is the requested drug being prescribed for primary or hypogonadotropic hypogonadism?

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☐ Yes ☐ No

Q6. Is this request for a continuation of testosterone therapy?

☐ Yes ☐ No

Q7. 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?

☐ Yes ☐ No

Q8. Does the patient have at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values?

☐ Yes ☐ No

Q9. Additional Information:

Q10. 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?

☐ Yes ☐ No

Q11. 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?

☐ Yes ☐ No

Q12. Is the requested drug being prescribed for delayed puberty?

☐ Yes ☐ No

Prescriber Signature _____ Date _____

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2024 Prior Authorization Request