



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.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, and 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.

Form with fields for Drug Name, Strength, and 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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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is this request for a continuation of testosterone therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Is the requested drug being prescribed for delayed puberty?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Prescriber Signature

Date

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Patient Name:	Prescriber Name:
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2024 Prior Authorization Request