

## 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 i	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	e (if applicable):
REQUEST FOR EXPEDITED REVIEW: By checking this be the enrollee or the enrollee's ability to regain maximum fu		v timeframe may seriously jeopardize the life or health of
Drug Name:		
Strength:  Directions / SIG:		
Directions / Sig.		
	tory including labs and information for these answer the following questions and si	
Q1. Is the drug being prescribed for age-related hypogonadism (late-onset hypogonadism)?		
☐ Yes	□ No	
Q2. What is the requested drug be	eing prescribed for?	
☐ Breast Cancer (Hormone-Re	esponsive Tumor) ? Go to Questi	on 3.
□ Delayed Puberty		
☐ Inoperable Metastatic Breas	st Cancer ? Go to Question 6.	
☐ Primary or Hypogonadotrop	ic Hypogonadism ? Go to Questic	on 7.
Q3. Is the patient premenopausal	?	
☐Yes	□No	
Q4. Has the patient benefited fron	n oophorectomy?	
☐ Yes	□ No	
Q5. Is the tumor considered horm	one-responsive?	

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



## 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:	
☐ Yes	□ No	
Q6. Is the patient 1 to 5 years postmenopausal?		
☐ Yes	□ No	
Q7. Is the request for continuation?		
☐ Yes	□ No	
Q8. Before starting therapy, did the patient have at least two confirmed low morning testosterone levels per guidelines or lab reference?		
☐ Yes	□ No	
Q9. Before starting therapy, did the patient have at least one confirmed low morning testosterone level per guidelines or lab reference?		
☐ Yes	□ No	
Q10. Additional Information:		
Prescriber Signature	Date	

v2025