Jefferson Health Plans

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. Is the drug being prescribed for age-related hypogonadism (late-onset hypogonadism)?

☐ Yes ☐ No

Q2. What is the requested drug being prescribed for?

☐ Breast Cancer (Hormone-Responsive Tumor) ? Go to Question 3.
☐ Delayed Puberty
☐ Inoperable Metastatic Breast Cancer ? Go to Question 6.
☐ Primary or Hypogonadotropic Hypogonadism ? Go to Question 7.

Q3. Is the patient premenopausal?

☐ Yes ☐ No

Q4. Has the patient benefited from oophorectomy?

☐ Yes ☐ No

Q5. Is the tumor considered hormone-responsive?

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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