Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Testosterone Replacement Therapy

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 requested drug being prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q2. Is the patient prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Does the patient have a history of a contraindication to the prescribed medication?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of hypogonadism?

☐ Yes ☐ No

Q5. Does the patient have clinical and laboratory findings, including on two separate occasions: two low testosterone levels, OR luteinizing hormone [LH], follicle-stimulating hormone [FSH], supporting the diagnosis?

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☐ Yes ☐ No

Q6. Does the patient have a diagnosis of gender dysphoria?

☐ Yes ☐ No

Q7. Is the requested drug prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine?

☐ Yes ☐ No

Q8. Is the requested drug prescribed in a manner consistent with the current World Professional Association for Transgender Health standards of care for the health of transsexual, transgender, and gender nonconforming people?

☐ Yes ☐ No

Q9. Is the requested drug being prescribed for “age-related hypogonadism” (also referred to as “late-onset hypogonadism”)?

☐ Yes ☐ No

Q10. Is this a request for a formulary testosterone product?

☐ Yes ☐ No

Q11. Does the patient have a history of therapeutic failure with a formulary testosterone product? Provide documentation of previous medication(s) tried, including duration of trial.

☐ Yes ☐ No

Q12. Additional Information:

Prescriber Signature

Date

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