



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Injectable Testosterone Products - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

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.

Member Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Medicare Advantage	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 applying the 72 hour 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 request for continuation of therapy? If YES, go to 2. If NO, go to 3.

☐ Yes

☐ No

Q2. Has the patient's response to testosterone therapy been evaluated? Please provide documentation of the patient's response to therapy.

☐ Yes

☐ No

Q3. Is the medication being used for a diagnosis of hypogonadism?

☐ Yes

☐ No

Q4. Is the medication being used for a medically accepted indication not otherwise excluded from Part D (please provide documentation of diagnosis)?

☐ Yes

☐ No

Q5. Do labs show low testosterone levels in comparison to lab reference values on 2 separate occasions (include labs)?

☐ Yes

☐ No



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Member Name:	Prescriber Name:
Q6. Does the patient experience symptoms as a result of testosterone deficiency? Please include explanation of symptoms. ☐ Yes ☐ No	
Q7. Requested Duration: ☐ 12 Months ☐ Other	
Q8. Additional Information:	

Prescriber Signature

Date

v2025