



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Topical 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.**

|                                                               |                                                 |               |
|---------------------------------------------------------------|-------------------------------------------------|---------------|
| <b>Member Name:</b>                                           | <b>Prescriber Name:</b>                         |               |
| Member Number:                                                | Fax:                                            | Phone:        |
| Date of Birth:                                                | Office Contact:                                 |               |
| Line of Business: <input type="checkbox"/> Medicare Advantage | NPI:                                            | State Lic ID: |
| Address:                                                      | Address:                                        |               |
| City, State ZIP:                                              | City, State ZIP:                                |               |
| Primary Phone:                                                | <b>Specialty/facility name (if applicable):</b> |               |

☐ **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 reauthorization of the medication? 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 patient 18 years of age or older?

☐ Yes

☐ No

Q4. Is the medication being used for a diagnosis of hypogonadism? If YES, go to 6.

☐ Yes

☐ No

Q5. Is the medication being used for a medically accepted indication not otherwise excluded from Part D? (Please provide documentation of diagnosis) If YES, go to 8.

☐ Yes

☐ No



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|                                                                                                                                                                                                                                      |                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| <b>Member Name:</b>                                                                                                                                                                                                                  | <b>Prescriber Name:</b> |
| Q6. Do labs show low testosterone levels in comparison to lab reference values on 2 separate occasions (include labs)?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                   |                         |
| Q7. Does the patient experience symptoms as a result of testosterone deficiency (include explanation of symptoms)?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                       |                         |
| Q8. Does the patient have any contraindications to testosterone therapy including the following: carcinoma of the breast, known or suspected prostate cancer, pregnancy?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                         |
| Q9. Requested Duration:<br><input type="checkbox"/> 12 Months <input type="checkbox"/> Other:                                                                                                                                        |                         |
| Q10. Additional Information:                                                                                                                                                                                                         |                         |

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2025