Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Testosterone Replacement Therapy

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners 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:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: **Specialty/facility name (if applicable):**	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 this request for the treatment of gender dysphoria? (If so, please refer to the Treatment of Gender Dysphoria criteria).

☐ Yes ☐ No

Q2. Is the request for a preferred product?

☐ Yes ☐ No

Q3. Is the request for a male?

☐ Yes ☐ No

Q4. Is the member 18 years old or greater?

☐ Yes ☐ No

Q5. Is Androgel being prescribed for the sole use of erectile dysfunction?

☐ Yes ☐ No

Q6. Do labs show low testosterone levels on 2 separate occasions? Please include labs and collection dates.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q7. Does the member have one or more of the following symptoms: fatigue, depression, anemia, gynecomastia, and/or reduced muscle strength?

☐ Yes ☐ No

Q8. Are labs including hematocrit, PSA, LFT's, lipids, being monitored? Please attach labs.

☐ Yes ☐ No

Q9. Are there any contraindications including prostate or breast cancer, hematocrit >50 percent, untreated severe sleep apnea, prostate-specific antigen (PSA) concentration >4.0 mcg/L, or >3.0 mcg/L in high-risk men (African-Americans or men with first-degree relatives with prostate cancer), or uncontrolled heart failure?

☐ Yes ☐ No

Q10. Have possible risks of treatment with testosterone been discussed with the member? Risks include erythrocytosis, exacerbation of prostate cancer, benign prostatic hyperplasia (BPH), and cardiovascular disease.

☐ Yes ☐ No

Q11. Requested Duration:

☐ 6 months

Q12. Additional information:___

Prescriber Signature

Date

Updated 2018