Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] testosterone 1 % (25 mg/2.5 gram) transdermal gel packet [ ] testosterone 1 % (50 mg/5 gram) transdermal gel packet [ ] testosterone 1.62 % (20.25 mg/1.25 gram) transdermal gel packet [ ] testosterone 1.62 % (40.5 mg/2.5 gram) transdermal gel packet [ ] testosterone 10 mg/0.5 gram/actuation transdermal gel pump [ ] testosterone 100 mg implant pellet [ ] testosterone 100 mg/mL intramuscular suspension [ ] testosterone 12.5 mg/1.25 gram per pump actuation (1%) transdermal gel [ ] testosterone 20.25 mg/1.25 gram per pump act.(1.62 %) transdermal gel [ ] testosterone 200 mg implant pellet [ ] testosterone 30 mg/actuation (1.5 mL) transderm solution metered pump [ ] testosterone 50 mg implant pellet [ ] testosterone 50 mg/5 gram (1 %) transdermal gel [ ] testosterone 50 mg/mL intramuscular solution
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Hypogonadism

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q4: Does the member have a follow-up total serum testosterone level drawn that is within or below the normal limits of the reporting lab? (Check only one that apply)

[ ] Yes (please specify the current total testosterone level, reference range and the date of test) _____(*Required)

[ ] No

Q5: Does the member have a follow-up total serum testosterone level drawn that is outside of upper limits of normal for the reporting lab and the dose is adjusted? (Check only one that apply)

[ ] Yes (please specify the current total testosterone level, reference range and the date of test and new adjusted dose) _____(*Required)

[ ] No

Q6: Does the member have a condition that may cause altered sex-hormone binding globulin (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? (Check only one that apply)

[ ] Yes (please specify member's condition that may cause altered sex-hormone binding globulin) _____(*Required)

[ ] No (please provide medical justification for the continuation of therapy) _____(*Required)

Q7: Does the member have a follow-up calculated free or bioavailable testosterone level drawn that is within or below the normal limits of the reporting lab? (Check only one that apply)

[ ] Yes (please specify the lab test, the date for lab test and lab values) _____(*Required)

[ ] No

Q8: Does the member have a follow-up calculated free or bioavailable testosterone level drawn that is outside of upper limits of normal for the reporting lab and the dose is adjusted? (Check only one that apply)

[ ] Yes (please specify the lab test, the date for lab test and lab values) _____(*Required)

[ ] No (please provide medical justification for the continuation of therapy) _____(*Required)

Q9: What is the member's diagnosis? (Check only one that apply)

[ ] Hypogonadism

[ ] Gender Dysphoria/Gender Incongruence

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q10: Was the member a male at birth? (Check only one that apply)

[ ] Yes

[ ] No

Q11: Is the member at least 18 years old? (Check only one that apply)

[ ] Yes

[ ] No (please specify member's age and provide clinical rationale for the request)
_____(*Required)

Q12: Does the member have two pre-treatment serum total testosterone levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab? (Check only one that apply)

[ ] Yes (please specify the two pre-treatment serum total testosterone level, reference range and the date of test)
_____(*Required)

[ ] No

Q13: Does the member have a condition that may cause altered sex-hormone binding globulin (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? (Check only one that apply)

[ ] Yes (please specify member's condition that may cause altered sex-hormone binding globulin)
_____(*Required)

[ ] No

Q14: Does the member have one pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab? (Check only one that apply)

[ ] Yes (please specify the lab test, the date for lab test and lab values)
_____(*Required)

[ ] No

Q15: Does the member have history of any one of the following: (Check only one that apply)

[ ] Bilateral orchiectomy

[ ] Panhypopituitarism

[ ] A genetic disorder known to cause hypogonadism (please specify the disorder e.g., congenital anorchia, Klinefelter's syndrome) _____(*Required)

[ ] No

Q16: Is the member continuing testosterone therapy? (Check only one that apply)

[ ] Yes

[ ] No

Q17: Does the member have follow-up total serum testosterone level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab? (Check only one that apply)

[ ] Yes (please specify the lab test, the date for lab test and lab values)
_____(*Required)

[ ] No

Q18: Does the member have follow-up total serum testosterone level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted? (Check only one that apply)

[ ] Yes (please specify the lab test, date of test, lab values and new adjusted dose)
_____(*Required)

[ ] No (please provide medical justification for therapy) _____
(*Required)

Q19: Is the request for Testosterone cypionate? (Check only one that apply)

[ ] Yes

[ ] No

Q20: Is the member 12 years of age or older? (Check only one that apply)

[ ] Yes

[ ] No (please specify member's age) _____(*Required)

Q21: Is the member 18 years of age or older? (Check only one that apply)

[ ] Yes

[ ] No (please specify member's age) _____(*Required)

Q22: Is the member a transgender male (female-to-male)? (Check only one that apply)

[ ] Yes

[ ] No (please provide medical justification for the therapy) _____
(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the HealthPlan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	