

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.**

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have one of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Hypogonadism <input type="checkbox"/> Gender Dysphoria
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? <i>If yes, list condition:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient taking any of the following? <i>(If yes, check which applies and complete section D above)</i> <input type="checkbox"/> Genotropin, Humatrope, Norditropin FlexPro, Norditropin NordiFlex, Nutropin, Nutropin AQ, Omnitrope, Saizen, Tev-Tropin <input type="checkbox"/> Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])
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HYPOGONADISM

<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the patient male at birth?
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have <u>two</u> pre-treatment serum total testosterone levels less than 300 ng/dL (< 10.4 nmol/L) or less than the reference range for the lab, taken at separate times? <i>If yes, document lab value and date for both levels:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have <u>one</u> pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (< 5 ng/dL or < 0.17 nmol/L) or less than the reference range for the lab? <i>If yes, document lab value and date for both levels:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Bilateral orchiectomy <input type="checkbox"/> Panhypopituitarism <input type="checkbox"/> A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Significant reduction in weight (less than 90% ideal body weight) (e.g., AIDS wasting syndrome) <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Decreased bone density <input type="checkbox"/> Decreased libido <input type="checkbox"/> Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)
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GENDER DYSPHORIA

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of gender dysphoria as defined by the current version of the Diagnostic and Statistical Manual and Mental Disorders (DSM)?
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient using hormones to change physical characteristics?
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CONTINUATION OF THERAPY *(continued on next page)*

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had follow-up total serum testosterone level drawn within the past 12 months, with <u>one</u> of the following results? <i>(If yes, check which applies and document lab value and date)</i> <input type="checkbox"/> Within or below the normal male limits of the reporting lab <i>Document value and date:</i> <input type="checkbox"/> Outside of upper male limits of normal for the reporting lab and the dose is adjusted <i>Document value and date:</i>
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**Testosterone - Arizona
Prior Authorization Request Form**

Member First name:	Member Last name:	Member DOB:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has the patient had follow-up calculated free or bioavailable testosterone level drawn within the past 12 months, with <u>one</u> of the following results? <i>(If yes, check which applies and document lab value and date)</i></p> <p><input type="checkbox"/> Within or below the normal male limits of the reporting lab <i>Document value and date:</i></p> <p><input type="checkbox"/> Outside of upper male limits of normal for the reporting lab and the dose is adjusted <i>Document value and date:</i></p>	

Provider Signature: _____ **Date:** _____

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