Excellus

Drug Prior Authorization FAX Form

Testosterone
for
Oral, Injectable, or Topical
Rx Benefit

Complete this form and fax to:

☐ Pharmacy **Help Desk**
Fax: 1-800-956-2397
Phone: 1-800-499-1275

Complete ALL the following Patient/Prescriber information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Location of Infusion:
☐ **Prescriber office** ☐ **Home/Homecare agency:**_____
☐ **Outpatient facility:** ☐ **Other:** _____

Servicing Prescriber NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

Medication/Medical and Dispensing Information

Medication (HCPCS)	Dose	Frequency	Height	Weight (lbs. or kg)	Procedure Code

Diagnosis/ICD-10:

Is this request for a: ☐ New Start **OR** ☐ ***Continuation of Therapy (recertification)? Start Date: _____
****For Continuation of Therapy criteria, see # 4****

Questions/Indications for Medical Necessity

1. List symptoms the patient is experiencing: _____, _____, _____

2. Serum Testosterone levels (provide two (2) lab results collected within the past twelve (12) months)

Date of lab	Time sample collected	Serum Testosterone Level
a.		
b.		

3. List any previous testosterone therapies attempted:

Drug Name	Strength & Dosing	Period of use	Outcomes
		Start: End:	
		Start: End:	

***Continuation of Therapy**

4. Provide documentation of diagnosis prior to initiation of replacement therapy, as well as documentation of normal serum testosterone levels on two (2) separate occasions while receiving replacement therapy. (*Provide progress notes & lab reports)

Date of lab	Time sample collected	Serum Testosterone Level
a.		
b.		

Provide any other comments/clinical justification:

ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.

***Prescriber Signature:** _____ **Date:** _____
I certify the above is true and accurate to the best of my knowledge.

FOR QUESTIONS OR HELP WITH COMPLETING THIS FORM CALL: 1-800-363-4658
URGENT REQUESTS ONLY: 1(800) 208-4050 (fax)