



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

# Azmiro (testosterone cypionate)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
<b>Urgency:</b>					
<input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
<b>Medication requested:</b>					
<input type="checkbox"/> AZMIRO 200mg/mL Prefilled Syringe in Oil for Injection					
Dose:		Frequency of therapy:		Duration of therapy:	
What is your patient's current treatment plan (include target dose and titration plan)?					
Please provide clinical support for requesting this DOSE and/or QUANTITY for your patient (examples include past medications tried, pertinent patient history).					
<b>Where will this medication be obtained?</b>					
<input type="checkbox"/> CVS Caremark <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify):			<input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor		
<b>Facility and/or doctor dispensing and administering medication:</b>					
Facility Name:		State:		Tax ID#:	
Address (City, State, Zip Code):					
<b>Where will this drug be administered?</b>					
<input type="checkbox"/> Patient's Home <input type="checkbox"/> Hospital Outpatient			<input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (please specify):		
<p><b>NOTE:</b> Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.</p> Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale):					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					

**Diagnosis related to use:****ICD10:**

Hypogonadism (Primary or Secondary) in Males [Testicular Hypofunction/Low Testosterone with Symptoms]. Note: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression.

Delayed Puberty or Induction of Puberty in Males. Note: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression.

Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Female-To-Male (FTM) Gender Reassignment (that is, Endocrinologic Masculinization). Note: In this context, the specified gender is defined as follows: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression; females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression.

To Enhance Athletic Performance

other (please specify):

**Clinical Information:**

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy".

new start

continuation of therapy

(if gender dysphoric, incongruent, reassignment) Is this drug being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of transgender patients?  Yes  No

(if hypogonadism) Has the patient had persistent signs and symptoms of androgen deficiency (pre-treatment, meaning prior to the initiation of any testosterone therapy)? Note: Signs and symptoms of androgen deficiency include depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, and loss of libido.  Yes  No

(if hypogonadism) Is this initial therapy or is the patient currently receiving Testosterone Therapy?

Initial therapy

Currently receiving testosterone therapy

None of the above or unknown

**If hypogonadism and initial therapy or unknown:**

Has the patient had TWO pre-treatment serum testosterone (total or bioavailable) measurements, each taken in the early morning, on two separate days?  Yes  No

Were the TWO serum testosterone levels BOTH low, as defined by the normal laboratory reference values?  Yes  No

The covered alternatives are: 1. Testosterone cypionate intramuscular injection (Depo-testosterone); 2. Testosterone enanthate intramuscular injection (Delatestryl). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regard to the covered alternatives?

The patient tried one of the alternatives, but it didn't work

The patient tried one of the alternatives, but they did not tolerate it

The patient cannot try one of these alternatives because of a contraindication to this drug

Other

**If hypogonadism and Currently receiving testosterone therapy:**

Did the patient have at least ONE pre-treatment serum testosterone (total or bioavailable) level with a low result as defined by the normal laboratory reference values?  Yes  No

**Additional Pertinent Information:** (All diagnoses) Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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