Aveed

(*testosterone undecanoate)*

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call
(800) 882-4462 (800.88.CIGNA)

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:		

Urgency:

☐ Standard ☐ 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)

Medication requested:

☐ Aveed 750mg/3ml (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, etc).

Where will this medication be obtained?

☐ CVS Caremark
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

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? ☐ Yes ☐ No (provide medical necessity rationale):

Diagnosis related to use: ICD10:

☐ Hypogonadism (Primary or Secondary) in Males [Testicular Hypofunction/Low Testosterone with Symptoms]
☐ Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Female-To-Male (FTM) Gender Reassignment (that is, Endocrinologic Masculinization)
☐ To Enhance Athletic Performance
☐ other (please provide the patient's diagnosis or reason for treatment.):

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? ☐ Yes ☐ No

Clinical Information:

(if gender) 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) Is this initial therapy or is the patient currently receiving Testosterone Therapy?
☐ Initial therapy
☐ Currently receiving Testosterone Therapy
☐ None of the above

(if Hypogonadism, if Currently receiving) 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, if Currently receiving) 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

(if Hypogonadism, if Initial) 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, if Initial) 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

(if yes) Were the TWO serum testosterone levels BOTH low, as defined by the normal laboratory reference values? ☐ Yes ☐ No

(if gender or hypogonadism) Is the requested dosing 750 mg IM, followed by 750 mg injected after 4 weeks, then 750 mg injected every 10 weeks thereafter, or less per dose? ☐ Yes ☐ No

(if no) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

Additional pertinent information *(Please provide clinical rationale, pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), 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.*):

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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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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