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

Testopel
(testosterone pellets)

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: ☐ Testopel 75mg

Dosing: Duration of therapy: ICD10:

Is this a new start or continuation of therapy? ☐ new start ☐ continued therapy
If requesting more than 6 pellets (450mg total) per 90 days AND this is continued therapy:
While on Testopel, did your patient continue to have documented signs and symptoms of androgen deficiency? Yes ☐ No ☐
While on Testopel, did your patient continue to have a low total serum testosterone level (drawn in the early morning) defined as any of the following? Please include lab report.
☐ total testosterone level less than 264 ng/dL (9.2 nmol/L)
☐ total testosterone level below the laboratory's normal reference range
☐ free testosterone level below the laboratory's normal reference range
☐ none of the above
(if free testosterone) Was free testosterone measured by an equilibrium dialysis assay? Yes ☐ No ☐
Please provide clinical support for requesting this dose for your patient (including past doses tried, past medications tried, pertinent patient history).

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

Diagnosis related to use:
☐ hypogonadism or hypogonadotropic hypogonadism (HH) (congenital or acquired)
☐ delayed puberty
☐ aging
☐ improved performance
☐ other (please specify):

Clinical Information:

****This drug requires supportive documentation (chart notes, lab and test results, etc). Supportive documentation for all answers must be attached with this request****

If hypogonadism/HH:
Prior to Testopel, did/does your patient have documented signs and symptoms of androgen deficiency? Yes ☐ No ☐
(if yes) Please provide those signs or symptoms that your patient is experiencing.

(if yes) Please provide the details (date/time of draw and results, including the lab's normal reference range).

Prior to Testopel, did your patient have a low serum testosterone level that was drawn in the early morning and is defined as any of the following? Please include lab report.

☐ total testosterone level less than 264 ng/dL (9.2 nmol/L)
☐ total testosterone level below the laboratory's normal reference range
☐ free testosterone level below the laboratory's normal reference range
☐ none of the above

(if free testosterone) Was free testosterone measured by an equilibrium dialysis assay? Yes ☐ No ☐

Please provide the details (date/time of draw and results, including the lab's normal reference range). If details cannot be provided, please update the previous answer to "none of the above".

Prior to Testopel, did your patient have a SECOND low serum testosterone level that was drawn in the early morning on a **different** day and is defined as any of the following? Please include lab report.

☐ total testosterone level less than 264 ng/dL (9.2 nmol/L)
☐ total testosterone level below the laboratory's normal reference range
☐ free testosterone level below the laboratory's normal reference range
☐ none of the above

(if free testosterone) Was free testosterone measured by an equilibrium dialysis assay? Yes ☐ No ☐

While taking this drug, will you patient also receive another testosterone product?

☐ Yes or Possibly
☐ No

Please provide the details (date/time of draw and results, including the lab's normal reference range). If details cannot be provided, please update the previous answer to "none of the above".

****This drug requires supportive documentation (chart notes, lab and test results, etc). Supportive documentation for all answers must be attached with this request****

If delayed puberty:

(if continued therapy) Has your patient already been treated with Testopel for 6 months or longer? Yes ☐ No ☐

(if yes) Please provide clinical support for longer than short-term treatment in your patient.

Prior to Testopel, is there documentation that your patient has/had limited or no signs of puberty? Yes ☐ No ☐

Additional pertinent information: (*please include clinical support for the use of this drug in your patient)*

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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