Testopel
(testosterone pellets)

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: ☐ Testopel 75mg

Dosing: Duration of therapy: ICD10:

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 Delayed Puberty or Induction of Puberty in Males) 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 (4 to 6 months) in your patient. ☐ Yes ☐ No

Is there documentation of beneficial response? ☐ Yes ☐ No

Was your patient previously approved by Cigna to receive this drug? ☐ Yes ☐ No

(if new) Is the prescriber requesting MORE THAN the maximum dosage of 6 pellets (450mg), implanted no more frequently than every 90 days? ☐ Yes ☐ No

(if reauth) Is the prescriber requesting a dosage of MORE THAN 6 pellets (450mg), implanted no more frequently than every 90 days? ☐ Yes ☐ No

(if yes) Has the prescriber documented continued signs and symptoms of androgen deficiency? ☐ Yes ☐ No

(if yes) Does the patient have a persistent 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 below the laboratory's normal reference range
☐ Free testosterone level below the laboratory's normal reference range
☐ None of the above
☐ Unknown

(if free T) Was the free testosterone level performed by 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/unknown".

(if yes) How many TOTAL pellets are being requested? The usual maximum dosage is 6 pellets.

☐ 7 pellets
☐ 8 pellets
☐ 9 pellets
☐ 10 pellets
☐ 11 or more pellets

Please provide clinical support for the use of this drug in your patient (including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently).

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

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

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 (Primary or Secondary) in Males [Testicular Hypofunction/Low Testosterone with Symptoms]
☐ Delayed Puberty or Induction of Puberty in Males
☐ Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Female-To-Male (FTM) Gender Reassignment (that is, endocrinologic masculinization)
☐ To Enhance Athletic Performance
☐ none of the above (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) **Is your patient male? Yes ☐ No ☐

(if Hypogonadism) **Is your patient 18 years of age or older? Yes ☐ No ☐

(if Hypogonadism) Will your patient use Testopel with other testosterone products concurrently? Yes ☐ No ☐

if Hypogonadism, if new start:

(if Hypogonadism) Prior to Testopel, did/does your patient have persistent pre-treatment signs and symptoms of androgen deficiency (for example depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, and loss of libido)? Yes ☐ No ☐

(if yes) Please provide those signs or symptoms that your patient is experiencing.

(if Hypogonadism) 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 below the laboratory's normal reference range
☐ Free testosterone level below the laboratory's normal reference range
☐ None of the above
☐ Unknown

(if free T) Was the free testosterone level performed by 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/unknown".

(if Hypogonadism) 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 below the laboratory's normal reference range
☐ Free testosterone level below the laboratory's normal reference range
☐ None of the above
☐ Unknown

(if free T) Was the free testosterone level performed by 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/unknown".

if Hypogonadism, if continuation:

(if Hypogonadism) Are PRE-TREATMENT clinical records available (including lab records of testosterone levels and chart notes documenting signs and symptoms experienced BEFORE starting Testopel)?
☐ Yes
☐ No (records lost or unable to provide pre-treatment clinical information)

(if yes) Prior to Testopel, did/does your patient have persistent pre-treatment signs and symptoms of Androgen Deficiency (for example, depressed mood, decreased energy, progressive decrease in muscle mass, Osteoporosis, and loss of libido)? Yes ☐ No ☐

(if yes) Please provide those signs or symptoms that your patient was experiencing.

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 below the laboratory's normal reference range
☐ Free Testosterone Level below the laboratory's normal reference range
☐ None of the above
☐ Unknown

(if Free) Was the Free Testosterone Level performed by 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/unknown".

(if no [records lost or unable to provide pre-treatment clinical info]) Does your patient have a RECENT serum testosterone (total or free) measurement? Yes ☐ No ☐

(if yes) Did this recent testosterone level indicate appropriate treatment while receiving testosterone replacement therapy, as defined by any of the following? Please provide lab report.
☐ Total Testosterone level WITHIN the normal laboratory reference values
☐ Free Testosterone Level WITHIN the laboratory's normal reference range
☐ None of the above
☐ Unknown

(if Free) Was the Free Testosterone Level performed by 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/unknown".

(if Delayed) **Is your patient male? Yes ☐ No ☐

(if Delayed) **Is your patient 14 years of age or older? Yes ☐ No ☐

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

(if gender) Is this drug being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of transgender individuals? 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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