Testosterone Therapy

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:

☐ testosterone gel (packets)
☐ testosterone gel (metered dose bottle)
☐ testosterone solution (metered dose bottle)
☐ Androderm (patch)
☐ AndroGel (packets)
☐ AndroGel (gel metered dose bottle)
☐ Aveed (injection)
☐ Axiron (solution metered dose bottle)
☐ Fortesta (gel metered dose bottle)c
☐ Jatenzo capsule
☐ Natesto (nasal gel metered dose pump)
☐ Striant (buccal)
☐ Testim (gel tubes)
☐ Vogelxo (gel packets or tubes)
☐ Vogelxo (gel metered dose bottle)
☐ Xyosted (injection)

Dose: Frequency of therapy: Duration of therapy:

(for all but Xyosted)If requesting dosing above the following: 1 patch per day, 2 packets/tubes per day, 2 buccal systems per day OR 2 gel/solution bottles per 30 days, 3 nasal gel pumps per 30 days, has your patient been titrated to the requested dose? ☐ Yes ☐ No

(if Xyosted) Is this request for more than 4 injections (2mL)/month (or 1 injection per week)? ☐ Yes ☐ No

(if yes to either of the above questions) What previous doses has your patient tried?

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).

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:

Address (City, State, Zip Code):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

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Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Diagnosis related to use: ICD10:

☐ hypogonadotropic hypogonadism (HH) (hypogonadism or testicular hypofunction)
☐ gender dysphoria/reassignment (gender identity disorder/GID)
☐ other (please specify):

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:

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 ☐ continued therapy

(if HH) Prior to treatment, 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 HH) Please provide details for TWO pretreatment serum testosterone levels (date/time of draw and results, including the lab's normal reference range).

Prior to treatment, did your patient have a low serum testosterone level that was drawn in the early morning and is defined as any of the following?
☐ 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

Prior to treatment, 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?
☐ 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

Is there documentation that your patient has had <u>failure, inadequate response or intolerance</u> to any of the following (check all that apply):
☐ Androderm
☐ Androgel 1% or its generic (2.5gm, 5gm gel packets)
☐ Androgel 1.62% or its generic (1.25gm, 2.5gm gel packet or pump)
☐ Aveed
☐ Axiron
☐ Fortesta
☐ Jatenzo
☐ Natesto
☐ Striant
☐ Testim
☐ testosterone 50mg/5gm tube (1%) gel (generic for Testim)
☐ testosterone 10mg/0.5gm (2%) gel pump (generic for Fortesta)
☐ testosterone 2% (30mg/1.5ml) solution (generic for Axiron)
☐ testosterone cypionate injection (Depo-testosterone)
☐ testosterone enanthate injection (Delatestryl)
☐ Vogelxo
☐ Xyosted
☐ Other:
Please provide drug name(s), date(s) taken and what the documented results were for each drug tried:

Is there documentation that your patient <u>not a candidate for</u> any of the following (check all that apply):
☐ Androderm
☐ Androgel 1% or its generic (2.5gm, 5gm gel packets)
☐ Androgel 1.62% or its generic (1.25gm, 2.5gm gel packet or pump)
☐ Aveed
☐ Axiron
☐ Fortesta
☐ Jatenzo
☐ Natesto

☐ Striant
☐ Testim
☐ testosterone 50mg/5gm tube (1%) gel (generic for Testim)
☐ testosterone 10mg/0.5gm (2%) gel pump (generic for Fortesta)
☐ testosterone 2% (30mg/1.5ml) solution (generic for Axiron)
☐ testosterone cypionate injection (Depo-testosterone)
☐ testosterone enanthate injection (Delatestryl)
☐ Vogelxo
☐ Xyosted
☐ Other:

Please explain any reason why your patient is not a candidate for each drug checked above:

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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