Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Topical Testosterone Products - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for continuation of therapy?
☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q3. Is the medication being used for a diagnosis of hypogonadism?
☐ Yes ☐ No

Q4. Is the medication being used for a medically accepted indication (Please provide documentation of diagnosis)?
☐ Yes ☐ No

Q5. Is the medication being used for a medically accepted indication not otherwise excluded from Part D? Please provide documentation of diagnosis.
☐ Yes ☐ No

Q6. Does the patient experience symptoms as a result of testosterone deficiency (include explanation of symptoms)?
☐ Yes ☐ No

Q7. Does the patient have any contraindications to testosterone therapy including the following: carcinoma of the breast, known or suspected prostate cancer, pregnancy?
☐ Yes ☐ No

Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Topical Testosterone Products - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q8. Has the patient's response to testosterone therapy been evaluated? Please provide documentation of the patient's response to therapy.

☐ Yes ☐ No

Q9. Additional Information:

Q10. Requested Duration:

☐ 12 months ☐ Other:

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request