



Office use only: Reviewed by: _____
Review date: _____ Approved Denied

## Prior Authorization Form

### Androgenic Agents (testosterone, Androderm, Androgel, and Testim)

ONLY COMPLETED FORMS WILL BE RECEIVED

Drug Requested \_\_\_\_\_ Dosage: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Provider Specialty: \_\_\_\_\_ Office Fax: \_\_\_\_\_

#### 1. Patient History:

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

#### 2. Laboratory evaluation (copy of lab report REQUIRED):

Does the patient have 1 testosterone level below the lower limits of normal?  Yes  No

**Please attach any supporting clinical information that may be useful in the review of this prior authorization.**

**Fax completed form to (706) 549-8004. Your office will receive a response via fax.**