Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Testosterone Products – Medical Necessity Request

Complete pages 1 and 2 for New/Initial Requests

Contraindication Information:

Does the member have any of the following contraindications?

- Carcinoma of the breast: **Yes or No**
- Known or suspected carcinoma of the prostate: **Yes or No**
- Is pregnant or planning to become pregnant? **Yes or No**
- Is breastfeeding? **Yes or No**
- For Testosterone Cypionate only: Does the member have serious cardiac, hepatic or renal disease? **Yes or No**
- For Testosterone Enanthate only: Does the member have an allergy to sesame oil? **Yes or No**

Diagnosis Information (please select diagnosis and answer related questions):

□ Hypogonadism/Low Testosterone

*__Please fax two different lab results for either total/serum or free testosterone in the morning after an overnight fast and must show the time the specimen was taken from within the past 6 months of starting testosterone therapy.__

- Total/Serum Testosterone:
  - Level 1: _____ ng/dL. Date Taken: _____ Time Taken: _____
  - Level 2: _____ ng/dL. Date Taken: _____ Time Taken: _____
- Free Testosterone:
  - Level 1: _____pg/mL. Date Taken: _____Time Taken: _____
  - Level 2: _____pg/mL. Date Taken: _____Time Taken: _____
-
- Does the member have signs/symptoms or conditions suggestive of testosterone deficiency (eg, unexplained anemia)? **Yes or No**
- If Yes, please provide what signs or symptoms or conditions the member has.

_____

_____

□ Delayed Puberty

- Has the member responded to psychological support? **Yes or No**

□ Breast Cancer

- Is the member being managed by an Oncologist? **Yes or No**
- Is the cancer metastatic? **Yes or No**
- Is the member post-menopausal? **Yes or No**
  - If Yes, how many years post-menopausal? _____
    - Is the cancer inoperable? **Yes or No**
  - If No, has the member benefitted from oophorectomy? **Yes or No**
    - Is the member's tumor hormone responsive? **Yes or No**

□ Congenital disorder of sexual differentiation

- What is the specific diagnosis? _____
  - Is the member being managed by either a pediatric endocrinologist or a Urologist? **Yes or No**

□ Congenital urogenital anomaly

Physician office's signature*_____ Print Name_____

*** Form must be completed and signed by physician or licensed representative from the physician's office.**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

- Does the member have hypogonadism? **Yes or No**
- What is the specific diagnosis? _____
- Is the member being managed by either a pediatric endocrinologist or an Urologist? **Yes or No**

□ Gender Dysphoriar/Gender Incongruence

- For Adults:
    - Has the member been diagnosed by a mental health professional? **Yes or No**
    - Is the member being managed by a mental health professional? **Yes or No**
    - If mental health disorders are present, is the member reasonably well controlled? **Yes or No**
    - Does the member consent to treatment? **Yes or No**
    - Does the member have the capacity to make well informed decisions? **Yes or No**
- For Adolescents:
    - Has the member been diagnosed by a mental health professional trained in child and adolescent developmental psychopathology? **Yes or No**
    - Is the member being managed by a mental health professional trained in child and adolescent developmental psychopathology? **Yes or No**
    - Is the member managed by a pediatric endocrinologist or other clinician trained in pubertal induction and does the pediatric endocrinologist or other clinician trained in pubertal induction agree with sex hormone treatment? **Yes or No**
    - Has the member been informed of the potential irreversible effects, loss of fertility, and options to preserve fertility? **Yes or No**
    - Does the member consent to treatment? **Yes or No**

Does the member have the capacity to make well informed decisions? **Yes or No**

□ Other: _____

***Please fax <u>two</u> different lab results for either total or free testosterone from within the past 60 days.**

- Total Testosterone:
    - Level 1: _____ ng/dL. Date Taken: _____ Time Taken: _____
    - Level 2: _____ ng/dL. Date Taken: _____ Time Taken: _____
- Free Testosterone:
    - Level 1: _____pg/mL. Date Taken: _____ Time Taken: _____
    - Level 2: _____pg/mL. Date Taken: _____ Time Taken: _____

Physician office's signature*_____ Print Name_____

*** Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

****Complete this page ONLY for subsequent (renewal) requests****

1. Please select member's diagnosis and provide requested information.

□ Hypogonadism/Low Testosterone

- Has the member experienced symptomatic improvement? **Yes or No**

Please fax the lab results from within the past 60 days for the following.** ***Please note levels must be from while the member was receiving testosterone therapy**.**

Total/Serum Testosterone: _____ ng/dL. Date Taken: _____

Free Testosterone: _____pg/mL. Date Taken: _____

□ Delayed Puberty

□ Breast Cancer – Is the member being managed by an Oncologist? **Yes or No**

□ Congenital disorder of sexual differentiation **OR** □ Congenital urogenital anomaly

- Is the member being managed by either a pediatric endocrinologist or an Urologist? **Yes or No**

□ Gender Dysphoria/Gender Incongruence

- For Adults:
  - Has the member been diagnosed by a mental health professional? **Yes or No**
  - Is the member being managed by a mental health professional? **Yes or No**
  - If mental health disorders are present, is the member reasonably well controlled? **Yes or No**
  - Does the member consent to treatment? **Yes or No**
  - Does the member have the capacity to make well informed decisions? **Yes or No**
- For Adolescents:
  - Is the member being managed by a mental health professional trained in child and adolescent developmental psychopathology? **Yes or No**
  - Is the member managed by a pediatric endocrinologist or other clinician trained in pubertal induction? **Yes or No**
  - Has the member been informed of the potential irreversible effects, loss of fertility, and options to preserve fertility? **Yes or No**
  - Does the member consent to treatment? **Yes or No**
  - Does the member have the capacity to make well informed decisions? **Yes or No**
- Is the member developing characteristics consistent with the patient's gender goals? **Yes or No**
- Please provide the member's Total Testosterone level taken within the past 90 days.

***Please fax the lab results**

- Total Testosterone: _____ ng/dL. Date Taken: _____

□ Other: _____

***Please fax the lab results for the following:**

Total Testosterone: _____ ng/dL. Date Taken: _____

Free Testosterone: _____pg/mL. Date Taken: _____

2. Will the member be receiving another form of testosterone (i.e, gel, patch, injection) in conjunction with the requested medication? **Yes or No**
   a. If yes, please provide the clinical reason why 2 different forms of testosterone are needed.

_____

Physician office's signature*_____ Print Name_____

*** Form must be completed and signed by physician or licensed representative from the physician's office**.