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? **Yes or No**
- Is 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 lab results for total/serum and/or free testosterone levels in the morning (prior to 12PM) after an overnight fast from TWO different days taken from within 6 months before starting testosterone therapy. NOTE, labs must show the time the specimen was taken.__

- Total/Serum Testosterone:
  - Level 1: ________ ng/dL. Date Taken: __________ Time Taken: __________ Overnight fast?: **Yes or No**
  - Level 2: ________ ng/dL. Date Taken: __________ Time Taken: __________ Overnight fast?: **Yes or No**
- Free Testosterone:
  - Level 1: _________pg/mL. Date Taken: __________Time Taken: __________ Overnight fast?: **Yes or No**
  - Level 2: _________pg/mL. Date Taken: __________Time Taken: __________ Overnight fast?: **Yes or No**

- Does the member have signs/symptoms or conditions suggestive of testosterone deficiency (e.g., 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 an Urologist? **Yes or No**

□ Congenital urogenital anomaly

- Does the member have hypogonadism? **Yes or No**
- What is the specific diagnosis? _________________________________

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: __________________

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

□ Gender Dysphoria/Gender Incongruence

- 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 informed of the potential irreversible effects, loss of fertility, and options to preserve fertility? **Yes or No**

□ Other: ______________________________________

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: __________________

<u>Complete this page ONLY for subsequent (renewal) requests**</u>**

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 6 months 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

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

   □ Congenital urogenital anomaly

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

   □ Gender Dysphoria/Gender Incongruence

   - 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**
   - Is the member developing characteristics consistent with the patient's gender goals? **Yes or No**
   - Please provide the member's Total/Serum Testosterone level taken within the past 90 days. ***Please fax the lab results**
     - Total/Serum Testosterone: ________ ng/dL. Date Taken: __________
   - For Adolescents:
     - Has the member been informed of the potential irreversible effects, loss of fertility, and options to preserve fertility? **Yes or No**

   □ Other: ______________________________________

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**.