



Attention: ACTION REQUESTED
 Prior Authorization DENIAL may occur unless complete information is provided

Reference: [PA#]

General Prior Authorization Form: Androderm or Androgel

FAX COMPLETED FORM TO QHP PHARMACY DEPT. Fax # 877-817-0842

Coverage Criteria:

-Covered Uses: All medically accepted indications not otherwise excluded from Part D.
-Required Medical Information: Hypogonadism (HG) (Initial): 1) One pre-treatment serum total testosterone (T) level less than 280 ng/dL (9.7 nmol/L) or less than reference range for the lab OR 2) Both of the following: Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). Diagnosis (dx) of HG in a male patient. (Reauth): 1) Total serum T level within or below the normal limits of the reporting lab, or 2) Total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Calculated free or bioavailable T level within or below the normal limits of the reporting lab, or calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
-Coverage Duration: New to Treatment: 6 months. New to Plan & Continuation of Treatment: 12 months. Reauthorization: 12 months.

Member Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Member ID#		NPI or DEA#:	
DOB:		Office Phone:	Office Fax:
Address:		Address:	
Home Phone:		Contact Person:	
Medication Information		Medical Information	
Medication Requested (drug name, strength and route of administration):		Drug Allergies:	
Medication Details (frequency, quantity):		Diagnosis:	
Expected Length of Therapy:		Prescriber's Signature/Date:	

Rationale for Prior Authorization

1. Please list other medications attempted for this patient:

Medication:	Reason therapy failed:	Length of therapy:
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Additional comments: _____

3. PLEASE INCLUDE RELEVANT MEDICAL RECORDS AND LAB REPORTS WITH YOUR REQUEST.

For Expedited Requests please call 1-877-233-7058
 Our Formulary List is located at <http://www.qualityhealthplansny.com>

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