



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)  
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)  
Androderm (Medicare Prior Authorization)**

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.  
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.  
When conditions are met, we will authorize the coverage of Androderm (Medicare Prior Authorization).

**Drug Name (select from list of drugs shown)**  
Androderm (testosterone td patch)

**Patient Information**

Patient  
Name: \_\_\_\_\_  
Patient ID: \_\_\_\_\_  
Patient  
Group No.: \_\_\_\_\_  
Patient  
DOB: \_\_\_\_\_

**Prescribing Physician**

Physician  
Name: \_\_\_\_\_  
Physician  
Phone: \_\_\_\_\_  
Physician  
Fax: \_\_\_\_\_  
Physician  
Address: \_\_\_\_\_  
City, State,  
Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Please circle the appropriate answer for each applicable question.

- |   |   |   |
|---|---|---|
| 1. Is the patient male?   | Y | N |
| [If the answer to this question is no, then no further questions are required.]   |   |   |
| 2. Does the patient have confirmed or suspected carcinoma of the prostate or breast?  | Y | N |
| 3. Is the patient being treated for primary hypogonadism (congenital or acquired)?  | Y | N |
| [If the answer to this question is yes, then skip to question 5.]   |   |   |
| 4. Is the patient being treated for secondary (i.e. hypogonadotropic) hypogonadism (e.g., idiopathic gonadotropin or LHRH deficiency)?  | Y | N |
| [If the answer to this question is no, then no further questions are required.]   |   |   |
| 5. Before the start of testosterone therapy did the patient (or does the patient currently) have a confirmed low testosterone level (i.e. morning total testosterone less than 300 ng/dL, morning free or bioavailable testosterone less than 5 ng/dL) or absence of endogenous testosterone? | Y | N |



**Arkansas  
BlueCross BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association

**Comments:**

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I affirm that the information given on this form is true and accurate as of this date.

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**Prescriber (Or Authorized) Signature and Date**