



Prior Authorization Form

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

Drug Name (select from list of drugs shown)

Androgel (testosterone td gel)

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 Y N
 prostate or breast?
3. Is the patient being treated for primary hypogonadism (congenital Y N
 or acquired)?
 [If the answer to this question is yes, then skip to question 5.]
4. Is the patient being treated for secondary (i.e. hypogonadotropic) Y N
 hypogonadism (e.g., idiopathic gonadotropin or LHRH
 deficiency)?
 [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 Y N
 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?



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

Comments:

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

Prescriber (Or Authorized) Signature and Date