



# Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

## Prior Authorization Form

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

#### Drug Name (select from list of drugs shown)

Testim (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 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



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**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**