ANDROGENS/ANABOLIC STEROID
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

BlueCross BlueShield of Oklahoma

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit *www.bcbsok.com*.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description:

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

*****Please note, a copy of lab results with reference range is required. Testosterone levels (free or total) must be confirmed with TWO early morning tests (between 7am and 11am) measured on two separate days. *****

Total Testosterone level(s) (please provide two pretreatment OR two current levels from within the last 12 months):

Pretreatment _____ng/dL Reference range _____ Date: _____ Time drawn: _____am / pm

Pretreatment _____ng/dL Reference range _____ Date: _____ Time drawn: _____am / pm

Current _____ng/dL Reference range _____ Date: _____ Time drawn: _____am / pm

Current _____ng/dL Reference range _____ Date: _____ Time drawn: _____am / pm

OR

Free Testosterone level(s) (please provide two pretreatment OR two current levels from within the last 12 months):

Pretreatment _____ng/dL Reference range _____ Date: _____ Time drawn: _____am / pm

Pretreatment _____ng/dL Reference range _____ Date: _____ Time drawn: _____am / pm

Current _____ng/dL Reference range _____ Date: _____ Time drawn: _____am / pm

Current _____ng/dL Reference range _____ Date: _____ Time drawn: _____am / pm

1. Is checking for testosterone levels medically inappropriate for the patient's gender? .....☐ Yes ☐ No

If yes, please provide explanation: _____

_____

Please continue on page 2.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For All Requests:

2. Is the patient currently receiving testosterone replacement therapy? ☐ Yes ☐ No
   If yes, when was treatment started: _____
3. Please select the patient's gender: ☐ Male ☐ Female
4. Please list all reasons for selecting the requested **medication, quantity and dosing schedule** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____
   _____
5. Please list all other medications the patient will take concomitantly with the requested medication. _____
   _____
6. Please list all medications the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if brand name, generic, extended-release products or OTC products)**:**

   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____

7. Has the patient had significant weight loss following surgery, infection, or trauma? ☐ Yes ☐ No
8. Does the patient have severe liver disease (Child Pugh Grade III-IV or refractory)? ☐ Yes ☐ No
9. Does the patient have severe renal disease (Stage 4-5)? ☐ Yes ☐ No
10. Does the patient have carcinoma of the breast? ☐ Yes ☐ No
11. Does the patient have known or suspected carcinoma of the prostate? ☐ Yes ☐ No
12. Does the patient have hypercalcemia? ☐ Yes ☐ No
13. Is the patient breastfeeding, pregnant or may become pregnant? ☐ Yes ☐ No
14. Does the patient have cardiac disease? ☐ Yes ☐ No
15. Does the patient have porphyria? ☐ Yes ☐ No

For Hypogonadism Diagnosis:

*****Please note, medical records including chart notes must be submitted as documentation to support signs/symptoms of hypogonadism.*****

16. Prior to testosterone replacement therapy, did the patient show signs/symptoms of hypogonadism? ☐ Yes ☐ No

For Anemia Diagnosis:

17. Please provide patient's hematocrit (Hct) value: _____ %
18. Is the patient's anemia caused by or associated with chronic renal failure? ☐ Yes ☐ No
19. Is the patient's anemia caused by deficient red cell production, including acquired aplastic anemia, congenital aplastic anemia, myelofibrosis and the hypoplastic anemias due to the administration of myelotoxic drugs? ☐ Yes ☐ No
20. **If no to both questions 18 and 19,** please provide the cause(s) of the patient's anemia: _____
21. Has the patient previously used an erythropoiesis-stimulating agent? ☐ Yes ☐ No
    If no, please provide explanation why: _____
    _____

For AIDS/HIV-associated Wasting Syndrome Diagnosis:

22. Please provide the patient's BMI: _____ kg/m^2
23. Has the patient had unexplained involuntary weight loss with obvious wasting? ☐ Yes ☐ No
    If yes, please provide the percent weight loss from baseline body weight: _____%
24. Have all other causes of weight loss been ruled out? ☐ Yes ☐ No

For Turner Syndrome Diagnosis:

25. Is the patient a child or adolescent? ☐ Yes ☐ No
26. Will the patient continue to be concurrently treated with growth hormone? ☐ Yes ☐ No

Please fax or mail this form to:
Blue Cross and Blue Shield of Oklahoma
c/o Prime Therapeutics LLC, Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.243.6930 Phone: 800.991.5643