Date of Request:____________________

Sterling Retiree Rx Prior Authorization Form

ANDRODERM, ANDROGEL, TESTIM

Indications for Coverage
Primary Hypogonadism (congenital or acquired)
Hypogonadotropic Hypogonadism (e.g., idiopathic gonadotropin or LHRH deficiency)
Testosterone Replacement Therapy

Required Medical Information
Prior to start of testosterone therapy, patient has a confirmed low testosterone level
(total testosterone less than 300 ng/dL; free or bioavailable testosterone less than 5 ng/dL)
or absence of endogenous testosterone.

Member Information					
Name					
Enrollment/Card-holder ID Number					
Group/Plan		**Male**		**Female**	
Date of Birth		**Age**		**Weight in Kg**	
Street Address					
City		**State**		**Zip**	

Physician Information					
Name					
Agent		**Contact Name**			
Specialty/Office					
Clinic Name					
Street Address					
City		**State**		**Zip**	
Phone		**Fax**			

Requested Drug		
	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request				
Labs: Baseline/Ongoing	**Strength/Dosage**			
Formulary Alternative(s) Attempted?	**Yes:**		**No:**	
Please List Alternative Formulary Drugs				
Comments				

Physicians Signature: ________________________________ **Fax Form to 1-877-847-9904**