Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Testosterone Products - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q2. Is the medication being used for a medically accepted indication not otherwise excluded from Part D?

☐ Yes ☐ No

Q3. Please list indication for use AND include documentation of the patient's diagnosis:

Q4. Do labs show low testosterone levels in comparison to lab reference values on two separate occasions? Must include labs.

☐ Yes ☐ No

Q5. Does the patient experience symptoms as a result of testosterone deficiency? Include explanation of symptoms.

☐ Yes ☐ No

Q6. Does the patient have any contraindications to testosterone therapy including the following:
A) Carcinoma of the breast
B) Known or suspected prostate cancer
C) Pregnancy?

☐ Yes ☐ No

Q7. Is the request for continuation of therapy?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q8. Has the patient's response to testosterone therapy been evaluated? Please provide documentation of the patient's response to therapy. ☐ Yes	☐ No
Q9. Additional Information:	
Q10. Duration: ☐ 12 months	

Prescriber Signature

Date

2021 Medicare Prior Authorization Request