KAISER PERMANENTE®

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Androgenic Agents (Topical Testosterone) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Androgenic Agents (Topical Testosterone).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:

□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5 – Diagnosis

1. Diagnosis of Primary or Secondary Hypogonadism? □ No □ Yes

6 – Clinical Criteria

2. Is the patient a male and > 18 years old?
   □ No □ Yes

3. Does the patient have a past medical history of prostate carcinoma or male breast carcinoma?
   □ No □ Yes

4. Has the patient had 2 separate serum testosterone levels, within the past 6 months, each drawn in the morning, which indicate a serum testosterone level below the normal range of 300 – 1,000 ng/dL? (submit results)
   □ No □ Yes

   Date: _____ Level: _____ Date: _____ Level: _____

Continuation of Therapy:

5. Has the patient achieved serum testosterone levels within the normal range of 300 – 1,000 ng/dL in the past 12 months? (submit results)
   □ No □ Yes
   Date: _____ Level: _____

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**