

Pharmacy Pre-authorization Form: Testosterone Replacement Therapy

Date: _____ Physician Name: _____
 Member Name: _____ Physician Specialty: _____
 Member ID Number: _____ Physician Address: _____
 Member Age: _____ Physician Telephone: _____
 Physician Fax/E-mail: _____

Medication requested (check one):

- Androderm Androgel Axiron Fortesta
 Striant Testim Testopel Injectable Testosterone*

1. Please provide diagnosis/physical symptoms being treated: _____ _____ ICD9/ICD10 code(s)* _____ <p style="text-align: center;">**ICD9/ICD 10 codes are required to process all requests.**</p>
2. Please provide patient's height _____ weight _____
3. Please attach applicable lab work, including total testosterone, free testosterone, LH, FSH, or prolactin. <p style="text-align: center;">**Lab reports are REQUIRED to process all requests.**</p>
4. Previous medications used (please indicate dates and outcome): _____ _____ _____
<p>* For injectable requests, please check one: <input type="checkbox"/> Provided by office <input type="checkbox"/> Patient will pick up at pharmacy</p>

For ConnectiCare Use Only:

Date reviewed: _____
 Approved/denied (circle one) by: _____ Approval expiration date: _____
 Comments: _____

**ConnectiCare Pharmacy Services: FAX — (860) 674-2851, or e-mail — pharmacy@connecticare.com
 To speak to a Medical Director or Pharmacist regarding a pre-authorization decision, call 1-800-828-3407.**

*This is confidential information. If you receive this form in error, please notify Provider Services immediately at 1-800-828-3407.
 The information in this document does not apply to ConnectiCare VIP Medicare plan members.*