Cigna®

Azmiro
(testosterone cypionate)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:

☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:

☐ AZMIRO 200mg/mL Prefilled Syringe in Oil for Injection

Dose: Frequency of therapy: Duration of therapy:

What is your patient's current treatment plan (include target dose and titration plan)?

Is the requested dosing up to 400 mg administered subcutaneously or intramuscularly every 1 to 4 weeks, not to exceed 400 mg every 2 weeks? ☐ Yes ☐ No

(if no) Please provide clinical support for requesting this DOSE and/or QUANTITY for your patient (examples include past medications tried, pertinent patient history).

Where will this medication be obtained?

☐ CVS Caremark
☐ Hospital Outpatient
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:

Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use: **ICD10:**

☐ Hypogonadism (Primary or Secondary) in Males [Testicular Hypofunction/Low Testosterone with Symptoms]. Note: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression.

☐ Delayed Puberty or Induction of Puberty in Males. Note: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression.

☐ Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Female-To-Male (FTM) Gender Reassignment (that is, Endocrinologic Masculinization). Note: In this context, the specified gender is defined as follows: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression; females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression.

☐ To Enhance Athletic Performance

☐ other (please specify):

Clinical Information:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy".
☐ new start
☐ continuation of therapy

(if gender dysphoric, incongruent, reassignment) Is this drug being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of transgender patients? ☐ Yes ☐ No

(if hypogonadism) Has the patient had persistent signs and symptoms of androgen deficiency (pre-treatment, meaning prior to the initiation of any testosterone therapy)? Note: Signs and symptoms of androgen deficiency include depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, and loss of libido. ☐ Yes ☐ No

(if hypogonadism) Is this initial therapy or is the patient currently receiving Testosterone Therapy?
☐ Initial therapy
☐ Currently receiving testosterone therapy
☐ None of the above or unknown

If hypogonadism and initial therapy or unknown:

Has the patient had TWO pre-treatment serum testosterone (total or bioavailable) measurements, each taken in the early morning, on two separate days? ☐ Yes ☐ No

Were the TWO serum testosterone levels BOTH low, as defined by the normal laboratory reference values? ☐ Yes ☐ No

The covered alternatives are: 1. Testosterone cypionate intramuscular injection (Depo-testosterone); 2. Testosterone enanthate intramuscular injection (Delatestryl). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regard to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work
☐ The patient tried one of the alternatives, but they did not tolerate it
☐ The patient cannot try one of these alternatives because of a contraindication to this drug
☐ Other

If hypogonadism and Currently receiving testosterone therapy:

Did the patient have at least ONE pre-treatment serum testosterone (total or bioavailable) level with a low result as defined by the normal laboratory reference values? ☐ Yes ☐ No

Additional Pertinent Information: (All diagnoses) *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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