Testopel
(testosterone pellets)

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: ☐ Testopel 75mg

Dosing: Duration of therapy: Frequency of therapy:

ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

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:

☐ Hypogonadism (Primary or Secondary) in Males [Testicular Hypofunction/Low Testosterone with Symptoms]
☐ Delayed Puberty or Induction of Puberty in Males
☐ Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Female-To-Male (FTM) Gender Reassignment (that is, endocrinologic masculinization)
☐ To Enhance Athletic Performance
☐ none of the above (please specify):

Clinical Information:

****This drug requires supportive documentation (chart notes, lab and test results, etc). Supportive documentation for all answers must be attached with this request****

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

(if Hypogonadism, if Currently receiving) 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, if Currently receiving) 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

(if Hypogonadism, if Initial) 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, if Initial) 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

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

Additional pertinent information: (*please include clinical support for the use of this drug in your patient)*

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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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