



Prescription Drug Coverage Determination Form
Testosterones
Androderm®, Androgel®, Testim® (testosterone)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Subscriber ID#: \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Physician Information

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Tax ID#: \_\_\_\_\_
Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person \_\_\_\_\_

Physician Signature (REQUIRED): \_\_\_\_\_ Date \_\_\_\_\_

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: \_\_\_\_\_ J-code: \_\_\_\_\_
Dose: \_\_\_\_\_ Directions: \_\_\_\_\_
Expected Duration of Therapy: \_\_\_\_\_

Prior Authorization Criteria:

- 1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?
2. Is the patient male?
3. Does the patient have a diagnosis of prostate cancer?
4. Does the patient have a diagnosis of breast cancer?
5. Does the patient have a testosterone deficiency (total testosterone <300 ng/dL, free or bioavailable testosterone <5 ng/dL) or absence of endogenous testosterone?

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): \_\_\_\_\_

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.