Prescriber Criteria Form Methyltestosterone 2025 PA Fax 3707-A v1 010125.docx Methitest (methyltestosterone tablets), Methyltestosterone Capsules Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Methyltestosterone.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient experienced an inadequate treatment response, intolerance or has a contraindication to an alternative testosterone product (e.g., topical testosterone, transdermal testosterone, injectable testosterone)? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for primary or hypogonadotropic hypogonadism? [Note: Safety and efficacy of testosterone products in patients with “age-related hypogonadism” (also referred to as “late-onset hypogonadism”) have not been established.] [If no, then skip to question 6.]	Yes ◯	No ◯
3	Is this request for a continuation of testosterone therapy? [If no, then skip to question 5.]	Yes ◯	No ◯
4	Before the patient started testosterone therapy, did the patient have a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines? [No further questions.]	Yes ◯	No ◯
5	Does the patient have at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines? [No further questions.]	Yes ◯	No ◯

6	Is the requested drug being prescribed for the treatment of delayed puberty? [If yes, then no further questions.]	Yes ◯	No ◯
7	Is the requested drug being prescribed for advancing inoperable metastatic breast cancer in a patient who is 1 to 5 years POSTmenopausal? [If yes, then no further questions.]	Yes ◯	No ◯
8	Is the requested drug being prescribed for a PREmenopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____