Prescriber Criteria Form Testosterone Topical 2025 PA Fax 1465-A v1 010125.docx Testosterone Products – Topical/Buccal/Nasal (Brand And Generic) Androderm (testosterone transdermal patch), Androgel, Fortesta, Testim, Vogelxo (testosterone topical gel), Natesto (testosterone nasal gel), Testosterone Topical Solution 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 Testosterone Products – Topical/Buccal/Nasal (Brand And Generic).

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	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 5.]	Yes	No
2	Is this request for a continuation of testosterone therapy? [If no, then skip to question 4.]	Yes	No
3	Before the patient started testosterone therapy, did the patient have a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values? [No further questions.]	Yes	No
4	Does the patient have at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values? [No further questions.]	Yes	No
5	Is the requested drug being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy?	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:____________________