Prescriber Criteria Form

Testosterone Enanthate 2024 PA Fax 1463-A v1 010124.docx
Testosterone Products – Injectable
Delatestryl (testosterone enanthate injection)
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 Delatestryl (testosterone enanthate injection).

Drug Name:
Delatestryl (testosterone enanthate injection)

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 serum total testosterone concentration based on the reference laboratory range or current practice guidelines? [No further questions.]	Yes	No
4	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
5	Is the requested drug being prescribed for delayed puberty? [If yes, then no further questions.]	Yes	No
6	Is the requested drug being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal AND has the patient had an incomplete	Yes	No

	response to other therapy for metastatic breast cancer? [If yes, then no further questions.]		
7	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? [If yes, then no further questions.]	Yes	No
8	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:**_____