P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth

PREAUTHORIZATION FORM

Brand and Generic formulations of:
Androgel®, Testim®, Axiron®, Fortesta™, Striant®, Androderm®
(testosterone)

Therapeutic use: Commonly used for the treatment male hypogonadism
Quantity Limit:

- ***Androgel:*** 100 mg daily
- ***Testim:*** 100 mg daily
- ***Axiron:*** 120 mg daily
- ***Fortesta:*** 70 mg daily
- ***Striant:*** 60 mg daily
- ***Androderm:*** 7.5 mg daily

Authorization Period: 12 months

Patient's name _____

Patient's ID# ☐☐☐☐☐☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐☐☐☐☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Which medication is being requested? ❑ Androgel ❑ Testim ❑ Axiron ❑ Fortesta ❑ Striant ❑ Androderm **Note: *Products are not covered for women.***		
2.	Has the member failed a trial of Androgel? **Note: Androgel is the preferred testosterone product and must be failed prior to approval of other products.**	❑ Yes	❑ No
3.	Does the patient have a total testosterone levels that fall below the normal range? Total testosterone level _____Date: _____.	❑ Yes	❑ No
4.	Does the patient experience clinical symptoms of malaise, fatigue, lethargy, muscle loss, depression, or decreased libido?	❑ Yes	❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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