

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.  
Please answer the following questions and sign.**

<p>Q1. Is the request for continuation of therapy? If No, skip to 3.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Has the patient's response to testosterone therapy been evaluated?  Please provide documentation of the patient's response to therapy. Skip to #7.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the medication being used for a diagnosis of hypogonadism?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is the medication being used for a medically accepted indication?  Please provide documentation of diagnosis.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Do labs show low testosterone levels in comparison to lab reference values on 2 separate occasions?  Please include labs.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the patient experience symptoms as a result of testosterone deficiency?  Please include explanation of symptoms.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Additional Information:</p>

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
Q8. Duration: <input type="checkbox"/> 12 months	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

2022 Medicare Prior Authorization Request