Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	_____/_____/_____ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Testopel**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____ *kg*

Patient Height: _____ *ft* _____ *inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process.*

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with question set.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Criteria Questions: **NOTE: Form must be completed in its entirety for processing**

1. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the **last 4 months**, excluding samples? ***Please select answer below:***

   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**

   ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions below:

2. Will the patient be using the requested medication in combination with any other form of testosterone? ❑Yes ❑No

3. What is the patient's diagnosis?

❑Deficiency of Testosterone / Hypogonadism

a. Has the patient had two morning total testosterone levels less than 300 ng/dL on different days? ❑Yes ❑No

b. What is the patient's hematocrit? _____ %

c. Has the patient had a prostatectomy? ❑Yes ❑No*

**If NO*, what the patient's baseline Prostate Specific Antigen (PSA)? _____ ng/ml ❑PSA not tested

d. Does the patient have a current diagnosis of prostate cancer? ❑Yes ❑No*

**If NO*, does the patient have palpable nodules? ❑Yes ❑No

e. Does the patient have a concurrent diagnosis of benign prostatic hyperplasia (BPH)? ❑Yes* ❑No

**If YES*, will the patient be monitored for worsening symptoms of BPH? ❑Yes ❑No

f. Does the patient have a diagnosis of sleep apnea? ❑Yes* ❑No

**If YES*, is the patient being treated for their sleep apnea? ❑Yes ❑No

g. Has the patient been evaluated for cardiovascular risks associated with myocardial infarction (MI), angina, and stroke? ❑Yes ❑No

❑Delay in Sexual Development and/or Puberty

a. Will the patient's bone age of the hand and wrist be assessed every six months as determined by radiographic evidence? ❑Yes ❑No

b. Will the patient be tested for liver function every six months? ❑Yes ❑No

c. Will the patient have their hematocrit level monitored every six months? ❑Yes ❑No

❑Gender Dysphoria (GD)

a. Has the patient met the DSM V criteria for gender dysphoria? ❑Yes ❑No

b. Is the patient undergoing a female to male transition? ❑Yes ❑No
c. Is this medication being prescribed by an endocrinologist or a prescriber who is experienced in treating this patient or others for gender dysphoria? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____

CONTINUATION OF THERAPY TESTOSTERONE INJECTION / IMPLANT (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the **last 4 months**, excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions below:

2. Will the patient be using the requested medication in combination with any other form of testosterone? ❑Yes ❑No
3. What is the patient's diagnosis?

❑Deficiency of Testosterone / Hypogonadism
a. Does the patient have a total testosterone level 800 ng/dL or less? ❑Yes ❑No
b. Does the patient have a concurrent diagnosis of benign prostatic hyperplasia (BPH)? ❑Yes* ❑No
If YES, have the symptoms associated with BPH worsened since beginning testosterone therapy? ❑Yes ❑No
c. Will the patient's serum testosterone concentrations be monitored every 12 months? ❑Yes ❑No
d. Has the patient had a prostatectomy? ❑Yes ❑No*
If NO, will the patient's Prostate Specific Antigen (PSA) be tested every 12 months? ❑Yes ❑No
e. Will the patient's hematocrit levels be monitored every 12 months? ❑Yes ❑No
f. Has the patient been re-evaluated for cardiovascular risks associated with myocardial infarction (MI), angina, and stroke? ❑Yes ❑No

❑Delay in Sexual Development and/or Puberty
a. Will the patient's bone age of the hand and wrist be assessed every six months as determined by radiographic evidence? ❑Yes ❑No
b. Will the patient be tested for liver function every six months? ❑Yes ❑No
c. Will the patient have their hematocrit level monitored every six months? ❑Yes ❑No

❑Gender Dysphoria (GD)
a. Is the patient undergoing a female to male transition? ❑Yes ❑No
b. Is this medication being prescribed by an endocrinologist or a prescriber who is experienced in treating this patient or others for gender dysphoria? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**
Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox** **1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program** **P.O. Box 312320, Detroit, MI 48231-2320**