Member Name: ______________________________ Member ID: _______________ Member DOB: _______________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Testosterone Products – Medical Necessity Request

Complete pages 1 and 2 for New/Initial Requests

Contraindication Information:

Does the member have any of the following contraindications?

- Carcinoma of the breast: **Yes or No**
- Known or suspected carcinoma of the prostate: **Yes or No**
- Pregnant: **Yes or No**
- May become pregnant: **Yes or No**
- Breastfeeding: **Yes or No**
- Serious cardiac, hepatic or renal disease: **Yes or No**
- Hypogonadal conditions not associated with structural or genetic etiologies: **Yes or No**
- Hypersensitivity to sesame oil: **Yes or No**
- Hypersensitivity to refined castor oil or benzyl benzoate: **Yes or No**

Diagnosis Information (please select diagnosis and answer related questions):

□ Hypogonadism

*__Please fax lab results for two total/serum testosterone levels OR one total/serum testosterone level and one free testosterone level from TWO different mornings (prior to 12PM) taken from within 6 months before starting testosterone therapy. NOTE, labs must show the time the specimen was taken.__

- Total/Serum Testosterone Level 1: ________ ng/dL. Date Taken: __________ Time Taken: __________
- Total/Serum Testosterone Level 2: ________ ng/dL. Date Taken: __________ Time Taken: __________
- Free Testosterone Level: ________________ pg/mL. Date Taken: __________ Time Taken: __________
- Does the member have signs/symptoms or conditions suggestive of testosterone deficiency? **Yes or No**
  - **If Yes**, please provide what signs or symptoms or conditions the member has.

    ____

    ____

□ Delayed Puberty

- Has the member responded to psychological support? **Yes or No**

□ Breast Cancer

- Is the member being managed by an Oncologist? **Yes or No**
- Is the cancer metastatic? **Yes or No**
- Is the member post-menopausal? **Yes or No**
  - **If Yes**, how many years post-menopausal? _____
    - Is the cancer inoperable? **Yes or No**
  - **If No**, has the member benefitted from oophorectomy? **Yes or No**
    - Is the member's tumor hormone responsive? **Yes or No**

□ Congenital disorder of sexual differentiation

- What is the specific diagnosis? _________________________________
  - Is the member being managed by a pediatric endocrinologist or urologist? **Yes or No**

□ Congenital urogenital anomaly

- Does the member have hypogonadism? **Yes or No**

Physician office's signature*________________________________ **Print Name**_______________________________

*** Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

- What is the specific diagnosis? ___________________________________
- Is the member being managed by a pediatric endocrinologist or urologist? **Yes or No**

□ Gender Dysphoria/Gender Incongruence

- If mental health disorders are present, is it reasonably well controlled? **Yes or No**
- Does the member consent to treatment and have the capacity to make well informed decisions? **Yes or No**
- For Adolescents ONLY: Has the member been informed of the potential irreversible effects, loss of fertility, and options to preserve fertility? **Yes or No**

□ Other: ____

Physician office's signature*________________________________ Print Name________________________________

*** Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Complete this page ONLY for subsequent (renewal) requests

Diagnosis Information (please select diagnosis and answer related questions):

□ Hypogonadism

*__Please fax lab results for a total/serum testosterone level taken from within the past 6 months. NOTE, labs must be from while the member was receiving testosterone therapy.__

- Total/Serum Testosterone Level: ________ ng/dL. Date Taken: _________
- Does the total/serum testosterone level exceed the testing laboratory's upper limit of the normal range? **Yes or No**
    - **-If Yes**, is the request for a dose decrease or will the dose be held until testosterone testing results are within the testing laboratory's normal range? **Yes or No**
- Has the member experienced symptomatic improvement? **Yes or No**
    - **-If No**, is the request for a different product or for a dose increase? **Yes or No**

□ Delayed Puberty

□ Breast Cancer

□ Congenital disorder of sexual differentiation

□ Congenital urogenital anomaly

□ Gender Dysphoria/Gender Incongruence

- Is the member developing characteristics consistent with the member's gender goals? **Yes or No**
- Please fax lab results for a total/serum testosterone level taken from within the past 6 months.
    - Total/Serum Testosterone Level: ________ ng/dL. Date Taken: _________

□ Other: ______________________________________

Physician office's signature*________________________________ Print Name_______________________________

*** Form must be completed and signed by physician or licensed representative from the physician's office**.