



**ANDROGENS  
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING  
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

**Please check drug requested below:**

- Testosterone topical (Androderm<sup>®</sup>, Androgel<sup>®</sup>, Testim<sup>®</sup>, Fortesta<sup>®</sup>, Axiron<sup>®</sup>)     Testosterone buccal (Striant<sup>®</sup>)
- Testosterone cypionate injection (Depo-Testosterone<sup>®</sup>)     Methyltestosterone (Android<sup>®</sup>, Methitest<sup>®</sup>, Testred<sup>®</sup>)
- Testosterone enanthate injection (Delatestryl<sup>®</sup>)     Fluoxymesterone (Androxy<sup>®</sup>)

**Dx Code:** \_\_\_\_\_ **Patient's Gender:** \_\_\_\_\_

**Please answer the following questions:**

For which of the following conditions is this androgen being prescribed? ***Please check at least one and answer the associated questions, if any.***

- Male for the treatment of hypogonadism (low testosterone)**
  1. Does (or did) the patient have symptoms of androgen deficiency?.....Yes No
  2. Has at least one baseline serum testosterone level been obtained? .....  Yes No

**If yes, please check one of the options below:**

  - Total testosterone level ≤ 300 ng/dl (10.4 nmol/L)
  - Total testosterone level > 300 ng/dl (10.4 nmol/L)
  - Free testosterone level (measured by the equilibrium dialysis method) ≤ 50 pg/ml (0.17 nmol/L)
  - Free testosterone level (measured by the equilibrium dialysis method) > 50 pg/ml (0.17 nmol/L)
- For palliative treatment of metastatic inoperable breast cancer**
- Male with delayed puberty**
- Other** (Medical record documentation may be required) \_\_\_\_\_

**Please certify the following by signing and dating below:**

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): \_\_\_\_\_ Date: \_\_\_\_\_

**For BCBSNC members, fax form to 1-800-795-9403**