



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Azmiro

(testosterone cypionate)

| PHYSICIAN INFORMATION | | | PATIENT INFORMATION | | |
|------------------------|--------------------|------|--|------------------|------|
| * Physician Name: | | | *Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.* | | |
| Specialty: | * DEA, NPI or TIN: | | | | |
| Office Contact Person: | | | * Patient Name: | | |
| Office Phone: | | | * Cigna ID: | * Date of Birth: | |
| Office Fax: | | | * Patient Street Address: | | |
| Office Street Address: | | | City: | State: | Zip: |
| City: | State: | Zip: | Patient Phone: | | |

Urgency: Standard Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)**Medication requested:** AZMIRO 200mg/mL Prefilled Syringe in Oil for Injection

Dose:

Frequency of therapy:

Duration of therapy:

What is your patient's current treatment plan (include target dose and titration plan)?

Is the requested dosing up to 400 mg administered subcutaneously or intramuscularly every 1 to 4 weeks, not to exceed 400 mg every 2 weeks? Yes No

(if no) Please provide clinical support for requesting this DOSE and/or QUANTITY for your patient (examples include past medications tried, pertinent patient history).

Where will this medication be obtained? CVS Caremark Hospital Outpatient Prescriber's office stock (billing on a medical claim form) Other (please specify): Retail pharmacy Home Health / Home Infusion vendor**Facility and/or doctor dispensing and administering medication:**

Facility Name:

State:

Tax ID#:

Address (City, State, Zip Code):

Where will this drug be administered? Patient's Home Hospital Outpatient Physician's Office Other (please specify):**NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? Yes No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? Yes No

Diagnosis related to use:

ICD10:

Hypogonadism (Primary or Secondary) in Males [Testicular Hypofunction/Low Testosterone with Symptoms]. Note: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression.

Delayed Puberty or Induction of Puberty in Males. Note: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression.

Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Female-To-Male (FTM) Gender Reassignment (that is, Endocrinologic Masculinization). In this context, the specified gender is defined as follows: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression; females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression.

To Enhance Athletic Performance

other (please specify):

Clinical Information:

(if gender dysphoric, incongruent, reassignment) Is this drug being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of transgender patients? Yes No

(if hypogonadism) Has the patient had persistent signs and symptoms of androgen deficiency (pre-treatment, meaning prior to the initiation of any testosterone therapy)? Note: Signs and symptoms of androgen deficiency include depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, and loss of libido. Yes No

(if hypogonadism) Is this initial therapy or is the patient currently receiving Testosterone Therapy?

Initial therapy

Currently receiving testosterone therapy

If hypogonadism and initial therapy:

Has the patient had TWO pre-treatment serum testosterone (total or bioavailable) measurements, each taken in the early morning, on two separate days? Yes No

Were the TWO serum testosterone levels BOTH low, as defined by the normal laboratory reference values? Yes No

Has the patient tried and, according to the prescriber, has had inadequate efficacy or significant intolerance to ONE of the following: Testosterone cypionate intramuscular injection (Depo-testosterone), OR Testosterone enanthate intramuscular injection (Delatestryl)? Yes No

If hypogonadism and Currently receiving testosterone therapy:

Did the patient have at least ONE pre-treatment serum testosterone (total or bioavailable) level with a low result as defined by the normal laboratory reference values? Yes No

Additional Pertinent Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

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