Fax completed form to: (855) 840-1678
If this is an URGENT request, please call
(800) 882-4462 (800.88.CIGNA)

Aveed
(testosterone undecanoate)

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:
☐ Aveed 750mg/3ml (injection)

Dose: Frequency of therapy: Duration of therapy:

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

Please provide clinical support for requesting this DOSE and/or QUANTITY for your patient (examples include past medications tried, pertinent patient history, etc).

Where will this medication be obtained?
☐ CVS Caremark
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

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

Clinical Information:

Is the requested medication going to be used to enhance athletic performance? ☐ Yes ☐ No

What is the patient's gender?
☐ Male (males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression)
☐ Female (females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression)

Does the patient have hypogonadism (primary or secondary) [testicular hypofunction/low testosterone with symptoms]? Note: For patients who have undergone gender reassignment, answer "no" to this question. ☐ Yes ☐ No

(if gender) Is the requested medication being used for gender-dysphoric/gender-incongruent persons; persons undergoing female-to-male (FTM) gender reassignment (that is, endocrinologic masculinization)? ☐ Yes ☐ No

(if gender) 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)? Please Note: Signs and symptoms of androgen deficiency include depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, and loss of libido. The pre-treatment timeframe refers to the signs and symptoms of androgen deficiency and serum testosterone levels prior to the initiation of any testosterone therapy. ☐ Yes ☐ No

(if hypogonadism) Is the patient currently receiving Testosterone Therapy? ☐ Yes ☐ No

(if Hypogonadism, if Currently receiving) 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

(if Hypogonadism, if not currently receiving) 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

(if Hypogonadism, if not currently receiving) Were the TWO serum testosterone levels BOTH low, as defined by the normal laboratory reference values? ☐ Yes ☐ No

(if gender or hypogonadism) Is the requested dosing 750 mg IM, followed by 750 mg injected after 4 weeks, then 750 mg injected every 10 weeks thereafter, or less per dose? ☐ Yes ☐ No

Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

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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