



Testopel (testosterone pellets)

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

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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Testopel 75mg Dosing: _____ Duration of therapy: _____ Frequency of therapy: _____ ICD10: _____					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): _____ **Cigna's nationally preferred specialty pharmacy					
<i>**Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557</i>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis related to use: <input type="checkbox"/> Hypogonadism (Primary or Secondary) in Males [Testicular Hypofunction/Low Testosterone with Symptoms] <input type="checkbox"/> Delayed Puberty or Induction of Puberty in Males <input type="checkbox"/> Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Female-To-Male (FTM) Gender Reassignment (that is, endocrinologic masculinization) <input type="checkbox"/> To Enhance Athletic Performance <input type="checkbox"/> none of the above					
Clinical Information: (if gender) Is the requested medication being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of transgender patients? <input type="checkbox"/> Yes <input type="checkbox"/> No (if Hypogonadism) Is this initial therapy or is the patient currently receiving Testosterone Therapy? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Currently receiving Testosterone Therapy <input type="checkbox"/> None of the above					

(if Hypogonadism) Has the patient had persistent signs and symptoms of androgen deficiency (pre-treatment)? 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, 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? Note: The pre-treatment timeframe refers to sign and symptoms of androgen deficiency and serum testosterone levels prior to the initiation of any testosterone therapy. Yes No

(if Hypogonadism, if Initial) Has the patient had TWO pre-treatment serum testosterone (total or bioavailable) measurements, each taken in the early morning, on two separate days? Note: The pre-treatment timeframe refers to sign and symptoms of androgen deficiency and serum testosterone levels prior to the initiation of any testosterone therapy. Yes No

(if yes) Were the TWO serum testosterone levels BOTH low, as defined by the normal laboratory reference values? Note: The pre-treatment timeframe refers to sign and symptoms of androgen deficiency and serum testosterone levels prior to the initiation of any testosterone therapy. 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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