



**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.  
Androgenic Agents (Topical Testosterone) Prior Authorization (PA)  
Pharmacy Benefits Prior Authorization Help Desk  
Length of Authorizations: Initial- 1 year; Continuation- 1 year**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Androgenic Agents (Topical Testosterone)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: <http://pithelp.appl.kp.org/MAS/formulary.html>**

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Provider Information**

Provider Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Provider Fax #: \_\_\_\_\_

Please check the boxes that apply:

Initial Request    Continuation of Therapy Request

Standard Review (72 hours)

Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature \_\_\_\_\_

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

Drug 2: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

### 5 – Diagnosis

Diagnosis of Primary or Secondary Hypogonadism?  No  Yes

### 6 – Clinical Criteria

**Initial Therapy:**

Is the patient a male and > 18 years old?

No  Yes

Does the patient have a past medical history of prostate carcinoma or male breast carcinoma?

No  Yes

Has the patient had 2 separate serum testosterone levels, within the past 6 months, each drawn in the morning, which indicate a serum testosterone level below the normal range of 300 – 1,000 ng/dL? (submit results)

No  Yes

Date: \_\_\_\_\_ Level: \_\_\_\_\_ Date: \_\_\_\_\_ Level: \_\_\_\_\_

**Continuation of Therapy:**

Has the patient achieved serum testosterone levels within the normal range of 300 – 1,000 ng/dL in the past 12 months? (submit results)  No  Yes

Date: \_\_\_\_\_ Level: \_\_\_\_\_

### 7 – Provider Sign-Off

**Additional Information – Please provide any additional information that should be taken into consideration.**

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

**Provider Signature:**

**Date:**

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility