

***For treatment of gender dysphoria,** see the Transgender Health Services section of the Physician-Related Services/Health Care Professional Services Billing Guide.

Provide the information below, please print your answers, attach supporting documentation, sign, date and return to our office as soon as possible to expedite this request.

Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082, Options 0,1,2,3.

Date of Request			
Patient	Date of Birth	Molina ID	
Pharmacy Name	Pharmacy NPI	Telephone Number	Fax Number
Prescriber	Prescriber NPI	Telephone Number	Fax Number
Medication and Strength		Directions for Use	Qty/Days Supply
<p>1. Indicate the diagnosis for your patient (check all that apply):</p> <p> <input type="checkbox"/> Late-onset (age-related) hypogonadism <input type="checkbox"/> Chronic high-dose glucocorticoid therapy <input type="checkbox"/> HIV-associated weight loss <input type="checkbox"/> Osteoporosis/low trauma fracture within previous 12 months. Provide T-score: _____ <input type="checkbox"/> Male with delayed puberty <input type="checkbox"/> Biologic female with advancing, inoperable metastatic breast cancer <input type="checkbox"/> Primary hypogonadism </p> <p> Due to: <input type="checkbox"/> Bilateral torsion <input type="checkbox"/> Cryptorchidism <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Klinefelter Syndrome <input type="checkbox"/> Orchiectomy <input type="checkbox"/> Orchitis <input type="checkbox"/> Trauma or toxic damage from alcohol or heavy metals <input type="checkbox"/> Vanishing testis syndrome </p> <p> <input type="checkbox"/> Secondary hypogonadism </p> <p> Select: <input type="checkbox"/> Idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency <input type="checkbox"/> Pituitary-hypothalamic injury from tumors, trauma or radiation </p> <p> <input type="checkbox"/> Biologic male with severely low testosterone who are symptomatic <input type="checkbox"/> Other. Specify: _____ </p>			

2. Provide your patient's two morning tests (between 8am to 10am) at least one week apart but no more than three months apart, demonstrating low testosterone levels (not applicable for diagnosis of metastatic breast cancer):

Total serum testosterone level: _____ ng/dL Total serum testosterone level: _____ ng/dL

Free testosterone level: _____ pg/mL Free testosterone level: _____ pg/mL

Date taken: _____ Date taken: _____

3. Provide your patient's follicle stimulating hormone (FSH) and luteinizing hormone (LH) levels at time of diagnosis (not applicable for diagnosis of metastatic breast cancer):

FSH: _____ LH: _____

4. If HIV-associated weight loss, provide the following for your patient:

Actual body weight: _____ Ideal body weight: _____

Target body weight goal: _____

Describe any changes in their weight during the last 6 months: _____

5. If chronic high-dose glucocorticoid therapy, provide the following for your patient:

Diagnosis requiring glucocorticoid regimen: _____

Current glucocorticoid regimen: _____ Expected duration of treatment: _____

6. If delayed puberty, indicate the following for your patient:

Has patient received a diagnosis of delayed puberty that is NOT secondary to a pathological cause? Yes No

Has patient's family history of delayed puberty been evaluated to support differential diagnosis of delayed puberty? Yes No

Has patient responded to "watchful waiting" with reassurance and psychological support in the previous 6 months? Yes No

Has patient completed puberty? Yes No

Is patient unable to sustain a normal serum testosterone concentration when not receiving testosterone therapy? Yes No

7. If metastatic breast cancer, indicate the following for your patient:

Has patient been postmenopausal for 1 to 5 years? Yes No

Is patient premenopausal and has demonstrated benefit from oophorectomy and has a hormone-responsive tumor? Yes No

Is this prescribed by, or in consultation with, an oncologist or a prescriber who specializes in treatment of metastatic breast cancer? Yes No

What first-line metastatic breast cancer treatments have been used?

What were the outcomes?

8. Indicate any of the following for your patient:

- | | | |
|--|------------------------------|-----------------------------|
| Breast cancer or known/suspected prostate cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Significant decrease in bone or muscle mass in the last 6 months | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Uncontrolled/poorly controlled benign prostate hyperplasia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| At higher risk of prostate cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Experienced a major cardiovascular event in the past six months | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Uncontrolled or poorly-controlled heart failure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Elevated hematocrit (>50%) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Untreated severe obstructive sleep apnea (OSA) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Severe lower urinary tract symptoms | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Receiving treatment for osteoporosis or low trauma fracture | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Severe adverse events related to testosterone therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pregnant or may become pregnant | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Supporting documentation required:

Laboratory and testing results and chart notes documenting diagnosis.

Prescriber Signature

Prescriber Specialty

Date