

Bravo Health

Coverage Review / Prior Authorization Request Form



Androgenic Medications

Androgel®, Depo-Testosterone®, Halotestin®, methyltestosterone, Testim®, Testoderm®, testosterone, Testopel®, Testred®

Patient Information	Prescriber Information
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Member Name:	Prescriber Name:
Bravo ID #	Prescriber Specialty:
DOB:	Prescriber Address:
Address:	
	Office Phone#:
Home Phone:	Office Fax #:
	Contact Person:

Diagnosis and Medication Requested

Medication Requested (dosage, frequency):	Qty:	
Prescribing Diagnosis:	ICD9 Code	Date Therapy Initiated:

Clinical Criteria

Please answer the following questions:

1. Does laboratory data indicate a serum testosterone level less than 300ng/ml?
Yes
No

***Laboratory Test and Results that provide serum testosterone levels and LH or FSH levels must be provided. Failure to provide adequate laboratory data could result in denial of this request. Laboratory data must be dated less than 30 days.**

2. Has coverage for the requested medication been sought and denied under Part B benefit?
Yes*
No

Additional Comments/Explanation:

Request for Expedited Review

<input type="checkbox"/>	REQUEST FOR EXPEDITED REVIEW [24 HOURS] BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION
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Prescriber's Signature: _____ Date: _____