

TeamstersCare Medication Prior Authorization Form



- ❖ Complete and fax to 617-241-5025.
- ❖ Standard response time is 3 to 5 business days from date received.

Testosterone Replacement

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

TeamstersCare ID#: _____

Patient Address: _____

Patient Phone: _____

PROVIDER INFORMATION

Provider Name: _____

Contact Person (If different than prescriber): _____

Office Phone: _____

Office Fax: _____

MEDICATION

Name/Strength: _____

DIAGNOSIS

Testosterone deficiency

Other: _____

Please circle the appropriate answer.

1. Is the patient a male? YES NO

2. Testosterone Levels: (2 levels w/date and time) **Level 1:** _____ Date: _____ Time: _____

Level 2: _____ Date: _____ Time: _____

Doctor's Signature: _____

Date: _____

FOR TEAMSTERSCARE USE ONLY

Eligibility Verified

Program: Active/MSTS ERMP RRX

Medication Requires PA

Prior PA? Yes No If Yes, Date: _____

Form Complete/Legible

Authorized Pended Denied

Patient Notified By: _____ Date: _____

Letter Sent By: _____ Date: _____

Notes:

Reviewer :

Date: