# 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. Total Testosterone Levels: (2 Total testosterone morning levels 8:00am-10:00am w/date and time)
   **Level 1:**_____ Date:_____ Time:_____
   **Level 2:**_____ Date:_____ Time:_____

Doctor's Signature: Date:

| FOR TEAMSTERSCARE USE ONLY | |
|---|---|
| Eligibility Verified ☐ | **Notes:** |
| 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: | **Reviewer :** **Date:** |