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 morning levels, prior to noon, w/date and time)

Level 1:_____ Date:_____ Time:_____

Level 2:_____ Date:_____ Time:_____

Please send a copy of most recent office visit notes

Provider'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:**

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