

Prescriber Criteria Form

Testosterone Cypionate 2025 PA Fax 1464-A v1 010125.docx  
 Testosterone Products - Injectable  
 Depo-Testosterone (testosterone cypionate injection)  
 Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Depo-Testosterone (testosterone cypionate injection).

Drug Name:  
 Depo-Testosterone (testosterone cypionate injection)

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for primary or hypogonadotropic hypogonadism? [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] [If no, then skip to question 5.]	Yes	No
2	Is this request for a continuation of testosterone therapy? [If no, then skip to question 4.]	Yes	No
3	Before the patient started testosterone therapy, did the patient have a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines? [No further questions.]	Yes	No
4	Does the patient have at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines? [No further questions.]	Yes	No
5	Is the requested drug being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy?	Yes	No

Comments:	
-----------	--

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

<b>Prescriber (or Authorized) Signature:</b> _____	<b>Date:</b> _____
--	--------------------