Catamaran Prior Authorization Department
Phone: 866-235-3062
Fax: 866-391-7222

Prescriber Information

Last Name:	**First Name**
DEA/NPI:	**Specialty:**
Phone	**Fax**

Member Information

Last Name:	**First Name**
Member ID Number	**DOB:**

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

Androgel
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Does the patient have suspected or known prostate or breast cancer?	Y	N
2. Does the patient have signs and symptoms of uncontrolled heart failure?	Y	N
3. Is the patient's hematocrit greater than 54%?	Y	N
4. Will treatment be stopped until hematocrit reaches a safe level below 54%?	Y	N
5. Does the patient have an allergy to soy?	Y	N
6. Does the patient have a diagnosis of Gender Identity Disorder/Gender Dysphoria and is in active treatment?	Y	N
7. Is the patient 18 years of age or older?	Y	N
8. Does the patient have confirmed low testosterone levels as measured by morning laboratory measurements on two separate occasions? Please document laboratory reference values and 2 of the following measurements: total serum testosterone, free testosterone, bioavailable testosterone from two separate occasions (please note: dates and reference range required). Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____	Y	N

9. Is the medication being requested for delayed puberty?	Y	N
10. Will the patient's bone development be monitored at least every six months?	Y	N

Striant
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Please document the patient's age: _____		
2. Does the patient have suspected or known prostate or breast cancer?	Y	N
3. Does the patient have signs and symptoms of uncontrolled heart failure?	Y	N
4. Is the patient's hematocrit greater than 54%?	Y	N
5. Will treatment be stopped until hematocrit reaches a safe level below 54%?	Y	N
6. Does the patient have an allergy to soy?	Y	N
7. Does the patient have a diagnosis of Gender Identity Disorder/Gender Dysphoria and is in active treatment?	Y	N
8. Does the patient have confirmed low testosterone levels as measured by morning laboratory measurements on two separate occasions? Please document laboratory reference values and 2 of the following measurements: total serum testosterone, free testosterone, bioavailable testosterone from two separate occasions (please note: dates and reference range required). Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____	Y	N
9. Is the medication being requested for delayed puberty?	Y	N
10. Will the patient's bone development be monitored at least every six months?	Y	N
11. Has the patient had a trial and failure of Androgel or Axiron, the preferred androgen products, after at least 60 days of therapy?	Y	N
12. Did the patient have an intolerance to Androgel or Axiron, the preferred androgen products in the past?	Y	N

Axiron
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Does the patient have suspected or known prostate or breast cancer?	Y	N
2. Does the patient have signs and symptoms of uncontrolled heart failure?	Y	N
3. Is the patient's hematocrit greater than 54%?	Y	N
4. Will treatment be stopped until hematocrit reaches a safe level below 54%?	Y	N
5. Does the patient have a diagnosis of Gender Identity Disorder/Gender Dysphoria and is in active treatment?	Y	N
6. Is the patient 18 years or older?	Y	N

7. Does the patient have confirmed low testosterone levels as measured by morning laboratory measurements on two separate occasions? Please document laboratory reference values and 2 of the following measurements: total serum testosterone, free testosterone, bioavailable testosterone from two separate occasions (please note: dates and reference range required). Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____	Y	N
8. Is the medication being requested for delayed puberty?	Y	N
9. Will the patient's bone development be monitored at least every six months?	Y	N

Android, Fortesta, Androderm, Testred, & Testim
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Please document the patient's age: _____		
2. Does the patient have suspected or known prostate or breast cancer?	Y	N
3. Does the patient have signs and symptoms of uncontrolled heart failure?	Y	N
4. Is the patient's hematocrit greater than 54%?	Y	N
5. Will treatment be stopped until hematocrit reaches a safe level below 54%?	Y	N
6. Does the patient have a diagnosis of Gender Identity Disorder/Gender Dysphoria and is in active treatment?	Y	N
7. Does the patient have confirmed low testosterone levels as measured by morning laboratory measurements on two separate occasions? Please document laboratory reference values and 2 of the following measurements: total serum testosterone, free testosterone, bioavailable testosterone from two separate occasions (please note: dates and reference range required). Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____	Y	N
8. Is the medication being requested for delayed puberty?	Y	N
9. Will the patient's bone development be monitored at least every six months?	Y	N
10. Has the patient had a trial and failure of Androgel or Axiron, the preferred androgen products, after at least 60 days of therapy?	Y	N
11. Did the patient have an intolerance to Androgel or Axiron, the preferred androgen products in the past?	Y	N

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Depo-Testosterone (testosterone cypionate) & Delatestryl (testosterone enanthate) Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Does the patient have suspected or known prostate or breast cancer?	Y	N
2. Does the patient have signs and symptoms of uncontrolled heart failure?	Y	N
3. Is the patient's hematocrit greater than 54%?	Y	N
4. Will treatment be stopped until hematocrit reaches a safe level below 54%?	Y	N
5. Does the patient have a diagnosis of Gender Identity Disorder/Gender Dysphoria and is in active treatment?	Y	N
6. Is the patient 18 years or older?	Y	N
7. Does the patient have confirmed low testosterone levels as measured by morning laboratory measurements on two separate occasions? Please document laboratory reference values and 2 of the following measurements: total serum testosterone, free testosterone, bioavailable testosterone from two separate occasions (please note: dates and reference range required). Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____ Date: _____Measurement (total serum/free/bioavailable): _____Laboratory Reference Range: _____	Y	N
8. Is the medication being requested for delayed puberty?	Y	N
9. Will the patient's bone development be monitored at least every six months?	Y	N

Comments: _____

Information given on this form is accurate as of this date.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 866-235-3062.

I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).