MOLINA® HEALTHCARE

Testosterone

***For treatment of gender dysphoria,** see the Transgender Health Services section of the Physician-Related Services/Health Care Professional Services Billing Guide.

Provide the information below, please print your answers, attach supporting documentation, sign, date and return to our office as soon as possible to expedite this request.
Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082.

Date of Request			
Patient	Date of Birth	Molina ID	
Pharmacy Name	Pharmacy NPI	Telephone Number	Fax Number
Prescriber	Prescriber NPI	Telephone Number	Fax Number
Medication and Strength	Directions for Use	Qty/Days Supply	

1. Indicate the diagnosis for your patient (check all that apply):

- ☐ Late-onset (age-related) hypogonadism
- ☐ Chronic high-dose glucocorticoid therapy
- ☐ HIV-associated weight loss
- ☐ Osteoporosis/low trauma fracture within previous 12 months. Provide T-score: _____
- ☐ Male with delayed puberty
- ☐ Biologic female with advancing, inoperable metastatic breast cancer
- ☐ Primary hypogonadism

  Due to:
  - ☐ Bilateral torsion
  - ☐ Cryptorchidism
  - ☐ Chemotherapy
  - ☐ Klinefelter Syndrome
  - ☐ Orchiectomy
  - ☐ Orchitis
  - ☐ Trauma or toxic damage from alcohol or heavy metals
  - ☐ Vanishing testis syndrome

- ☐ Secondary hypogonadism

  Select:
  - ☐ Idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency
  - ☐ Pituitary-hypothalamic injury from tumors, trauma or radiation

- ☐ Biologic male with severely low testosterone who are symptomatic
- ☐ Other. Specify: _____

2. Provide your patient's two morning tests (between 8am to 10am) at least one week apart but no more than three months apart, demonstrating low testosterone levels (not applicable for diagnosis of metastatic breast cancer):

Total serum testosterone level: _____ ng/dL Total serum testosterone level: _____ ng/dL

Free testosterone level: _____ pg/mL Free testosterone level: _____ pg/mL

Date taken: _____ Date taken: _____

3. Provide your patient's follicle stimulating hormone (FSH) and luteinizing hormone (LH) levels at time of diagnosis (not applicable for diagnosis of metastatic breast cancer):

FSH: _____ LH: _____

4. If HIV-associated weight loss, provide the following for your patient:

Actual body weight: Ideal body weight:

Target body weight goal:

Describe any changes in their weight during the last 6 months:

5. If chronic high-dose glucocorticoid therapy, provide the following for your patient:

Diagnosis requiring glucocorticoid regimen:

Current glucocorticoid regimen: Expected duration of treatment:

6. If delayed puberty, indicate the following for your patient:

Has patient received a diagnosis of delayed puberty that is NOT secondary to a pathological cause?	☐ Yes	☐ No
Has patient's family history of delayed puberty been evaluated to support differential diagnosis of delayed puberty?	☐ Yes	☐ No
Has patient responded to "watchful waiting" with reassurance and psychological support in the previous 6 months?	☐ Yes	☐ No
Has patient completed puberty?	☐ Yes	☐ No
Is patient unable to sustain a normal serum testosterone concentration when not receiving testosterone therapy?	☐ Yes	☐ No

7. If metastatic breast cancer, indicate the following for your patient:

Has patient been postmenopausal for 1 to 5 years?	☐ Yes	☐ No
Is patient premenopausal and has demonstrated benefit from oophorectomy and has a hormone-responsive tumor?	☐ Yes	☐ No
Is this prescribed by, or in consultation with, an oncologist or a prescriber who specializes in treatment of metastatic breast cancer?	☐ Yes	☐ No

What first-line metastatic breast cancer treatments have been used?

What were the outcomes?

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8. Indicate any of the following for your patient:

Breast cancer or known/suspected prostate cancer	☐ Yes	☐ No
Significant decrease in bone or muscle mass in the last 6 months	☐ Yes	☐ No
Uncontrolled/poorly controlled benign prostate hyperplasia	☐ Yes	☐ No
At higher risk of prostate cancer	☐ Yes	☐ No
Experienced a major cardiovascular event in the past six months	☐ Yes	☐ No
Uncontrolled or poorly-controlled heart failure	☐ Yes	☐ No
Elevated hematocrit (>50%)	☐ Yes	☐ No
Untreated severe obstructive sleep apnea (OSA)	☐ Yes	☐ No
Severe lower urinary tract symptoms	☐ Yes	☐ No
Receiving treatment for osteoporosis or low trauma fracture	☐ Yes	☐ No
Severe adverse events related to testosterone therapy	☐ Yes	☐ No
Pregnant or may become pregnant	☐ Yes	☐ No

Supporting documentation required:
Laboratory and testing results and chart notes documenting diagnosis.

Prescriber Signature	Prescriber Specialty	Date

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