Sterling SPECIALTY PHARMACY

Testicular Hypofunction
Prescription Referral Form
NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

1 Patient Information
Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

Patient Name: ______ Birthdate: ______ Sex: Male Female Height: ______ Weight: ______ lbs. kg.

Allergies: ______ Patient Primary Language: English Spanish Other: ______ Hearing Impaired

Patient Phone: ______ Patient Email: ______ Caregiver Name: ______

Patient Address: ______ City: ______ State: ______ Zip: ______

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2 Diagnosis/Clinical Information
Please FAX Clinical Notes, Labs, & Tests with the prescription to expedite Prior Authorization.

Check all that apply. Be sure to complete the information on the right-hand side.

Diagnosis:
- E29.1 Testicular Hypofunction
- Other: ______

Symptoms to Support TRT:
- R68.82 Decreased Libido
- M62.89 Loss of Muscle Mass
- N52.9 Erectile Dysfunction
- E28.0 Estrogen Excess
- Z79.890 Hormone Replacement Therapy
- R29.890 Vertebral Height Loss/Osteoporosis
- R89.1 Abnormal Levels of Hormones in Specimen from Other Organ/Tissue Type: ______ (e.g., Thyroid, HIV, etc.)

Reason for Autoinjector:
- F40.231 Needle Phobia
- T49.8 Underdosing with Topical TRT
- H54.7 Limited Vision

Prior Failed Treatments: Must be completed for all patients.

Treatment Type	Drug Name	Dates of Use
Testosterone Gel	______	______
Testosterone IM Injection	______	______
Testosterone Nasal	______	______
Testosterone Patch	______	______
Other: ______	______	______

Testosterone Lab Results: Must be completed for all patients.

Prior to starting testosterone therapy, did patient have low testosterone confirmed by 2 morning labs on separate days?
Yes No **If yes, include lab values with dates in chart.**

If patient is on testosterone therapy, include the above values and most recent lab report with dates (must be within last 6 months).

3 Prescription Information
Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
XYOSTED® (testosterone enanthate) Injection CIII	50mg/0.5ml Autoinjector 75mg/0.5ml Autoinjector 100mg/0.5ml Autoinjector	**Dose:** Inject SQ in the abdominal region once weekly, rotating site. Other: ______	4 ___	___
______	______	______	___	___

4 Provider/Prescriber Information

Clinic Name: ______ Provider Name: ______

Provider Phone: ______ Provider Fax: ______ DEA#: ______ NPI#: ______

Provider Address: ______ City: ______ State: ______ Zip: ______

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Dispense as Written: ______ Date: ______ Substitution Permissible: ______ Date: ______

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs.

IMPORTANT NOTICE: This fax is intended to be delivered to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.