# Testicular Hypofunction
## Prescription Referral Form

Sterling SPECIALTY PHARMACY

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**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: _____

## 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<br>❑ 75mg/0.5ml Autoinjector<br>❑ 100mg/0.5ml Autoinjector | ❑ **Dose:** Inject SQ in the abdominal region once weekly, rotating site.<br>❑ Other: _____ | ❑ 4<br>❑ ___ | ❑ ___ |
| ❑ _____ | ❑ _____ | ❑ _____ | ❑ ___ | ❑ ___ |

## 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**):

Signature: _____ Date: _____ Dispense as Written (Write "DAW")

**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.**