



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: _____

Reason for Autoinjector:

F40.231 Needle Phobia
T49.8 Underdosing with Topical TRT
H54.7 Limited Vision

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.)

Other Supporting Factors:

Testosterone Transference Risk to Women & Children
Q98.0 Klinefelter Syndrome
C62.90 Testicular Cancer
Orchiectomy (One or Both)
Z91.14 Patient's Other Noncompliance with Medication Regimen

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).

Provider has determined that the alternative treatment options would not be as effective as the prescribed medication, and therefore the requested medication is medically necessary.



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**):

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. 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.