



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: _____

Patient Phone: _____ Caregiver Name: _____ Hearing Impaired

Patient Address: _____ City: _____ State: _____ Zip: _____

Steady Care (copay card) Consent must be filled out completely.

Driver's License Number: _____

Driver's License State: _____

Email: _____

Patient consents to enrollment in Steady Care Program.



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

F64.9 Gender Identity Disorder

Q98.0 Klinefelter Syndrome

Other: _____

Reason for Autoinjector:

F40.231 Needle Phobia

T49.8 Underdosing with Topical TRT

H54.7 Limited Vision

R27.8 Lack of Coordination/Dexterity

Symptoms to Support TRT:

R68.82 Decreased Libido

M62.89 Loss of Muscle Mass

N52.9 Erectile Dysfunction

E28.0 Estrogen Excess

R29.890 Vertebral Height Loss/Osteoporosis

R89.1 Abnormal Levels of Hormones in Specimen from Other Organ/Tissue:

Thyroid Obesity

HIV Other: _____

Diabetes

Other Supporting Factors:

Testosterone Transference Risk to Women & Children

Orchiectomy (One or Both)

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.

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.

Pre-Treatment Levels *Must have two morning labs prior to treatment with lab levels below normal range*			
	Date:	Level:	Testosterone Type:
1			Total Testosterone Free Testosterone
2			Total Testosterone Free Testosterone

Existing TRT Patient *Must have lab showing levels outside the normal range*			
	Date:	Level:	Testosterone Type:
1			Total Testosterone Free Testosterone



3 Prescription Information

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

Medication	Dose/Strength	Direction	Qty.	Refills
TLANDO™ (testosterone undecanoate) Capsule CIII	112.5mg Capsules	Take 225mg (2 capsules) by mouth twice per day with food. Other: _____	120 _____	____
XYOSTED® (testosterone enanthate) Injection CIII	50mg/0.5ml Autoinjector 75mg/0.5ml Autoinjector 100mg/0.5ml Autoinjector	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.