BlueCross BlueShield Nebraska

Androgen Preauthorization Physician Fax Form

The following documentation is REQUIRED for preauthorization. Please fill out the ONE page of this form that meets the type of diagnosis for which the product is being prescribed. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Nebraska website at ***www.nebraskablue.com***.

Today's Date: _____

Patient Information

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):	Telephone Number:

Insurance Information

BCBSNE ID Number:

Physician/Clinic Information

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip Code:		Phone Number:		Secure Fax Number:

Preauthorization Information

Medication Requested: _____

Medication Dose Requested: _____

Diagnosis: _____

Height: _____ **Weight:** _____ **Gender:** _____

1. Is the patient currently being treated with testosterone replacement therapy?..... ☐ Yes ☐ No
   A. Is the patient currently being treated with the requested medication?..... ☐ Yes ☐ No
2. Has the patient tried and failed Axiron and Androgel?..... ☐ Yes ☐ No
3. Is checking testosterone levels medically appropriate for this patient's gender?..... ☐ Yes ☐ No
4. What is the requested medication being used to treat?

   ☐ Hypogonadism (low testosterone)

   A. What are the patient symptoms of androgen deficiency? _____

   B. What is the pre-treatment/baseline serum testosterone level (provide documentation)? _____

   ☐ Palliative treatment of metastatic inoperable breast cancer

   ☐ AIDS/HIV-associated wasting syndrome, defined as unexplained involuntary weight loss (>10% baseline body weight) with obvious wasting OR body mass index <18.5 kg/m2 AND all other causes of weight loss have been ruled out

   ☐ Adolescent with delayed puberty

   ☐ Anemia caused by deficient red cell production, including acquired aplastic anemia, congenital aplastic anemia, myelofibrosis and the hypoplastic anemias due to the administration of myelotoxic drugs

   ☐ Anemia associated with chronic renal failure AND either the patient has previously used an erythropoiesis-stimulating agent OR he/she has a documented intolerance, FDA labeled contraindication or hypersensitivity to an ESA (please provide documentation)

   ☐ Other (provide description and documentation) _____
5. Will the patient be treated with more than one androgen therapy?..... ☐ Yes ☐ No
6. If this is a renewal, describe any improvement in symptoms and include pertinent documentation:

   _____

   _____
7. Please list clinical information that should be included in this review:

   _____

   _____

Please fax additional information with this form if necessary and pertinent to this review.

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
1919 Aksarben Drive • PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726
Phone: 877-999-2374