VIVA MEDICARE

417 20th Street North Suite 1100
Birmingham, AL 35203
Fax Number: (205) 558-7506

Coverage Uses: All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria: A. Female. B. Carcinoma of the breast or known or suspected prostate cancer.
Required Information: Before the start of testosterone therapy patient had (or patient currently has) a confirmed low testosterone level (i.e., morning total testosterone less than 300 ng/dL, morning free testosterone less than 9 ng/dL) or absence of endogenous testosterone.
Coverage Duration: Plan Year

TOPICAL TESTOSTERONES COVERAGE DETERMINATION FORM

(ANDRODERM, ANDROGEL, ANDROGEL PUMP, AXIRON, FORTESTA, STRIANT, TESTIM)

*****Please Note Any Incomplete or Illegible Information Will Delay the Review Process*****

Patient Information:	Prescriber Information:
Patient Name:	**Physician:**
Member ID #:	**Office Phone #:**
Date of Birth:	**Office Fax #:**
Phone #:	**DEA #:**
Address:	**Office Contact:**

******Please Note that TESTIM is the only Preferred Tier 3 Product for 2014******

Medication and Diagnosis Information:		
Medication:	**Strength:**	
Route:	**Frequency:**	**Quantity:**

Coverage Criteria Questions:		
ICD Code/Diagnosis:		
1. Is the patient male? [If the answer to this question is no, then no more questions required]	**Yes**	**No**
2. Does the patient have the diagnosis of delayed puberty? [If the answer to this question is yes, proceed to question 7]	**Yes**	**No**
3. Does the patient have the diagnosis of hypogonadism? [If the answer to this question is yes, proceed to question 7]	**Yes**	**No**
4. Does the patient have the diagnosis of erectile dysfunction? [If the answer to this question is yes, proceed to question 7]	**Yes**	**No**
5. Does the patient have a diagnosis of breast cancer in which the requested medication will be used as palliative treatment?	**Yes**	**No**

6. Does the patient have carcinoma of the breast or known or suspected prostate cancer?	**Yes**	**No**
7. Before the start of testosterone therapy patient had (or patient currently has) a confirmed low testosterone level (i.e., morning total testosterone less than 300 ng/dL, morning free testosterone less than 9 ng/dL) or absence of endogenous testosterone.	**Yes**	**No**

*****Must Submit a copy of Pre-Treatment TESTOSTERONE LABORATORY RESULTS with this form*****

Request Type:	Required Information:
☐ **Prior Authorization**	**View Prior Authorization & Step Therapy Criteria at:** **www.vivamedicaremember.com/Resource/Current/Formulary.aspx**
☐ **Quantity Exception:**	Request for an exception to the plan's limit on the number of pills available per month. The prescriber must provide clinical documentation that the restricted dose has been found to be ineffective and all other formulary alternatives have been found to be, or based on sound clinical judgment would likely be, ineffective.
☐ **Tier Exception:**	Request for an exception to the tier level for a covered drug. The prescriber must provide information that the drug in the lower-cost sharing tier for the treatment of the member's condition was tried and failed, is contraindicated, or would not be as effective as the drug in the higher cost-sharing tier or would have adverse effects. Limitations: Cannot request a tier exception for Tier 5 Specialty medications, or brand medications for generic tier cost-sharing, or for drugs approved as a formulary exception.

Rationale for Request: (Required)
Prescriber's Signature: **Date:**
Prescriber's Specialty:

Request for Expedited Review:
☐ By checking this box, I certify that waiting 72 hours for a standard review may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.
For Urgent Requests Needed Within 24 Hours Please Provide an After-Hours Contact and Direct Phone Number: _____