# Sterling SPECIALTY PHARMACY

# Testicular Hypofunction

**NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371**



## 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:**

- ❑ Primary Testicular Hypofunction
- ❑ Secondary Testicular Hypofunction
- ❑ Gender Dysphoria
- ❑ Klinefelter Syndrome
- ❑ Other: _____

**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
  - ❑ HIV
  - ❑ Diabetes
  - ❑ Obesity
  - ❑ Other: _____

**Reason for Autoinjector:**

- ❑ F40.231 Needle Phobia
- ❑ T49.8 Underdosing with Topical TRT
- ❑ H54.7 Limited Vision
- ❑ R27.8 Lack of Coordination/Dexterity

**Other Supporting Factors:**

- ❑ Testosterone Transference Risk to Women & Children
- ❑ Orchiectomy (One or Both)
- ❑ Poor adherence to dietary requirements with other oral TRT
- ❑ Insufficient absorption with topical TRT

❑ 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 Naïve

| Testosterone Type | Drug Name | Dates Used |
|---|---|---|
| ❑ Gel | | |
| ❑ Intramuscular | | |
| ❑ Nasal | | |
| ❑ Oral | | |
| ❑ Patch | | |
| ❑ Implant | | |
| ❑ Other: | | |

**Testosterone Lab Results:** Must be completed for all patients.

❑ Pretreatment levels have been archived or are not available, as the patient was diagnosed by another provider. Provider attests that patient has low testosterone.

**Pre-Treatment Levels** *Must have two morning labs prior to treatment with lab levels below normal range*

| | Date: | Level: | Testosterone Type: |
|---|---|---|---|
| 1 | | | ❑ Total ❑ Free |
| 2 | | | ❑ Total ❑ Free |

**Existing TRT Patient** *Must have lab showing levels outside the normal range*

| | Date: | Level: | Testosterone Type: |
|---|---|---|---|
| 1 | | | ❑ Total ❑ Free |

## 3 Prescription Information

This form alone is not a valid prescription.

### If Faxing Prescriptions:

Fax to 866.588.0371

### If Calling In the Prescription:

1. You may call 888.618.4126 to get in touch with the pharmacist on duty directly.
2. Please leave a message with the prescription information if no answer.

### If eScripting Prescriptions:

Add **Sterling Specialty Pharmacy** to your EMR system using the following information:

1. **Sterling Specialty Pharmacy**
   1312 Northland Drive, Suite 500
   Mendota Heights, MN 55120

   *OR*

2. **NPI:** 1225548480

New York providers are required to send a valid eScript for testosterone therapy per state law.

## 4 Provider/Prescriber Information

❑ **I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization/Appeal process, nursing services, and patient assistance programs.**



Signature: _____ Date: _____

*Physician or clinical staff authorized to submit prior authorizations.*

Clinic Name: _____ Clinic Phone: _____ Clinic Fax: _____

Clinic Address: _____ City: _____ State: _____ Zip: _____