TESTICULAR HYPOFUNCTION
Prescription Referral Form

NPI:_____ Phone #:_____ Fax #: _____

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded that patients may choose a pharmacy of their choice.

PATIENT INFORMATION

Please fax front and back copy of ALL insurance cards (prescription and medical).

Patient Name:	Birthdate:	Sex: Male Female	Height:	Weight:
Allergies:	Patient Primary Language: English Spanish Other Hearing Impaired			
Patient Phone #:	Patient Email:	Caregiver Name:		
Patient Street Address:	City:	State:	ZIP:	

DIAGNOSIS/CLINICAL INFORMATION

Please fax clinical notes, labs, and tests with the prescription to expedite prior authorization.

Diagnosis:

E29.1 Testicular Hypofunction
E34.9 Endocrine Disorder
Other: _____

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: _____ (eg, Thyroid, HIV, etc)

Reason for Nasal Gel:

F40.231 Fear of injections and transfusions
D75.1 Secondary polycythemia
N50.0 Atrophy of testis
N46.021 Azoospermia due to drug therapy
N46.121 Oligospermia due to drug therapy
I10 Essential (primary) hypertension
I15.9 Secondary hypertension, unspecified
T49.8X5 Adverse effect of other topical
L25.1 Unspecified contact dermatitis due to drugs in contact with skin
Other _____

Prior Failed Treatments: Must be completed for all patients

Drug Name	Date of Use	Reason for Discontinuation

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 charts (include the last 12 months of medical chart notes).**

If patient is on testosterone therapy, include the above values and the most recent lab report with dates (must be within last 6 months).

MEDICATION REQUESTED

Medication	Dose/Strength	Direction	Qty	Refills
NATESTO® (testosterone), CIII	11 mg/4.5% testosterone	Apply 1 pump (5.5 mg) in each nostril, 3 times daily (33 mg total) 3 dispensers=30-day supply	3	

PROVIDER/PRESCRIBER INFORMATION

Client Name:	Provider Name:	NPI #:	
Provider Phone #:	Provider Fax #:	DEA #:	
Provider Street Address:	City:	State:	ZIP:

PRESCRIBER SIGNATURE: **Prescriber, please sign and date below (NO stamps please).**

Dispense as Written:	Date:	Substitution Admissable:	Date:

I authorize_____ and its representatives to act as an agent to initiate and execute the insurance prior authorization process, nursing services, and patient assistance programs.