Please indicate: Chart of treatment:	◆aetna	Injection) Request Page 1 of 2	stosterone Medication	Precertific	cation	Phone: <u>1-866</u> FAX: <u>1-888</u> For Medicare	tification Notification <u>-752-7021</u> (TTY: <u>711</u>) <u>-267-3277</u> Advantage Part B: ledicare Request Form	
Precertification Requested By:	Please indicate: Start of							
A. PATIENT INFORMATION DOB: First Name: Last Name: DOB: Address: City: State: ZIP: Patient Current Weightbs orkgs Patient Heightinches ororms Allergies: Email: Patient Current Weightbs orkgs Patient Heightinches ororms Allergies: Patient Current Weightbs orkgs Patient Heightinches ororms Allergies: City: State: ZIP: Medicatic: YesNo If yes, provide ID #: Medicatid: YesNo If yes, provide ID #: City: State: ZIP: Medicatic: YesNo If yes, provide ID #: Medicatid: YesNo If yes, provide ID #: City: State: ZIP: Medicatis: YesNO If yes, provide ID #: City: State: ZIP: Phone: Phone: Fax: State: ZIP: Phone:	🗌 Contin	nuation of therapy, Date of	last treatment	1 1				
First Name: Last Name: DDB: Address: City: State: ZIP: Patient Current Weight: Ibs or	Precertification Requested	Ву:		Phone	:	Fax:		
Adress: City: State: ZIP: Home Phone: Work Phone: Cell Phone: Email: Patient Current Weight Ibs or kgs Patient Height: inches or cms Allergies: Email: Patient Current Weight Ibs or kgs Patient Height: inches or cms Allergies: Email: Patient Current Weight Ibs or kgs Patient Have other coverage? C yes No Group #: If yes, provide ID#: Carrier Name: Carrier Name: Insured: Insured: Insured: City: State: ZIP. Phone: Fax: State: State: ZIP. Phone: Specialty (Check one): Endocrinologist Internist Otfice Contact Name: Phone: State: ZIP. Phone: Fax: State: Otfice Contact Name: Phone: Specialty Pharmacy: Patient Selected choice Outpatient Indusion Center Phone:	A. PATIENT INFORMATION							
Home Phone: Work Phone: Cell Phone: Email: Patient Current Weight lbs orkgs Patient Height:inches orcms Allergies: B. B. INSURANCE INFORMATION Acta Member 10 #:	First Name:		Last Name:			DOB:		
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B. INSURANCE INFORMATION Actna Momber ID #:	Home Phone:	Work Phone:		Cell Phone:		Email:		
B. INSURANCE INFORMATION Actna Momber ID #:	Patient Current Weight:	lbs or kgs Patier	nt Height: inch	ies or cms	Allergies:			
Aeta Member ID #; Does patient have other coverage? Yes No Group #;			<u> </u>		Ũ			
group #			Does patient have	other coverage?	🗌 Yes 🗌 No			
Medicare: Yes No If yes, provide ID #: Medicare: Yes No If yes, provide ID #: C. PRESCRIBER INFORMATION				-				
C. PRESCRIBER INFORMATION First Name: Last Name: (Check One): M.D. D.O. N.P. PA. Address: City: State: ZIP: Phone: Fax: St Lic #: NPI #: DEA #: UPIN: Provider Email: Office Contact Name: Phone: State: ZIP: Provider Email: Office Contact Name: Phone: Self-administration: Dispensing Provider/Pharmacy: Patient Selected choice Place of Administration: Center Name: Phone: Self-administreed Physician's Office Physician's Office Name: Address: Address: Address: Name: Address: TIN: Phone: Raddress: Raddress: Raddress: Raddress: TIN: Phone: Fax: TIN: Codres: Codres: <td< td=""><td>Insured:</td><td></td><td>Insured:</td><td></td><td></td><td></td><td></td></td<>	Insured:		Insured:					
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Address: City: State: ZIP: Phone: Fax: St Lic #: NPI #: DEA #: UPIN: Provider Email: Office Contact Name: Phone: Specialty (Check one): Endocrinologist □ Internist □ Other:			Last Name:		(Check (One): 🗌 M.D.	🗌 D.O. 🗌 N.P. 🗌 P.A.	
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Provider Email: Office Contact Name: Phone: Specialty (Check one): Endocrinologist Internist Other: D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION Place of Administration: Dispensing Provider/Pharmacy: Patient Selected choice Self-administration: Outpatient Infusion Center Phone: Dispensing Provider/Pharmacy: Patient Selected choice Outpatient Infusion Center Phone: Specialty Pharmacy Other Home Infusion Center Phone: Specialty Pharmacy Other Administration code(s) (CPT): Address: Phone: Fax: Address: Phone Fax: Name: Request is for: Aveed (testosterone undecanoate injection) Dose: Frequency: Frequency: F. DIAGNOSISI INFORMATION - Required clinical information must be completed in its entirety for all precertification requests. For All Requests (clinical documentation required): Secondary ICD Code: Other ICD Code: Other ICD Code: G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests. For All Requests (clinical documentation required): Gender dysphoria Image: No Has the patient has a ninferific versponse, contraindication, or intolerance to Depo-Testoste	Phone [.]	Fax [.]	St Lic.#	-	DEA #		UPIN	
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D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION Place of Administeration:				ne.		i none.		
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Self-administered Physician's Office □ P		ADMINISTRATION INFO	RMATION	Dienensing	Drevider/Dherme	Patient Ca	lasted shains	
□ Outpatient Infusion Center Phone: □ □ Home Infusion Center Phone: □ □ Agency Name: □ Address: □ □ Administration code(s) (CPT): □ Address: Phone: □ □ Administration code(s) (CPT): □ Phone: □ Phone: □ △ Administration code(s) (CPT): □ Phone: Fax: □ Address: □ Pine: □ Pine: □ E. PRODUCT INFORMATION Request is for: Aveed (testosterone undecanoate injection) Dose: Frequency: F F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable. Primary ICD Code:		Physician's Office				-		
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Agency Name: Address: Address: Phone: Fax: Phone: Fax: Phone: Fax: Phone: Fax: Phone: Fax: Phone: TIN: Phone: Fax: Phone: TiN: Phone:<				Name:				
Address:	Agency Name:							
E. PRODUCT INFORMATION Request is for: Aveed (testosterone undecanoate injection) Dose:		PT):						
Request is for: Aveed (testosterone undecanoate injection) Dose:				I IN:		PIN: _		
F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable. Primary ICD Code:					_			
Primary ICD Code: Other ICD Code: G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests. For All Requests (clinical documentation required): \[] Yes \] No Has the patient had an ineffective response, contraindication, or intolerance to Depo-Testosterone? For Initiation Requests (clinical documentation required): \[] Gender dysphoria \[] Yes \] No Is the patient less than 18 years of age? \[] Yes \] No Is the patient less than 18 years of age? \[] Yes \] No Is the patient less than 18 years of age? \[] Yes \] No Is the patient less than 18 years of age? \[] Yes \] No Is the patient less than 18 years of age? \[] Yes \] No Is the patient less than 18 years of age? \[] Yes \] No Is the patient sconcribed by or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health care provider? \[] Yes \] No Are the patient able to make an informed decision to engage in hormone therapy? \[] Yes \] No Has the patient been informed of fertility preservation options? \[] Yes \] No Is the requested drug prescribed for gender dysphoria in an adolescent patient? \[] Yes \] No Is the requested for gender dysphoria in an adolescent patient?	•		· · ·			ency:		
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 Yes No Has the patient been educated on any contraindications and side effects to therapy? Yes No Has the patient been informed of fertility preservation options? Yes No Is the requested drug prescribed for gender dysphoria in an adolescent patient? Please indicate the Tanner stage of puberty the patient has reached: 								
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☐ Yes ☐ No Is the requested drug prescribed for gender dysphoria in an adolescent patient?	·							
Please indicate the Tanner stage of puberty the patient has reached:								
🗌 Tanner stage I 🔲 Tanner stage II 🗌 Tanner stage III 📄 Tanner stage IV 📄 Tanner stage V 📄 Unknown	Please in	dicate the Tanner stage of pu	uberty the patient has	reached:				
	Tanne	er stage I 🔲 Tanner stage II	Tanner stage III	☐ Tanner stage Ⅳ [] Tanner stage V	Unknown		



Aveed[®] (testosterone undecanoate injection) Medication Precertification Request

Page 2 of 2

 Aetna Precertification Notification

 Phone:
 <u>1-866-752-7021</u>

 FAX:
 <u>1-888-267-3277</u>

For Medicare Advantage Part B: Please Use Medicare Request Form

(All fields must be completed and legible for precertification review.)

Patient First Name	Patient Last Name	Patient Phone	Patient DOB			
G. CLINICAL INFORMATION (co	ontinued) – Required clinical informati	on must be completed in its <u>entirety</u> fo	r all precertification requests.			
Primary hypogonadism H Other:	ypogonadotropic hypogonadism	Age-related hypogonadism 🗌 Late-o	nset hypogonadism			
Please indicate the patient's g	ender: 🔲 Biologic male or a person that	self identifies as male 🛛 Female				
🗌 Yes 🗌 No 🔲 Unknown	Prior to initiating therapy with the request	ed drug, did the patient have at least two	o confirmed (pre-treatment) low morning			
	serum total testosterone concentrations b	based on reference lab range or current p	practice guidelines?			
Yes No Is the copy of	the laboratory report with pretreatment m	orning serum total testosterone concent	rations attached to this request?			
For Continuation Requests (clinic	al documentation required):					
🗌 Gender dysphoria						
Yes INo Is the patient	, ,					
(e	the requested drug prescribed by or in cc .g., pediatric endocrinologist, family or int ental health care provider?		the care of transgender youth necologist) that has collaborated care with a			
☐ Yes ☐ No Are the patient's comorbid conditions reasonably controlled?						
Yes No Is the patient able to make an informed decision to engage in hormone therapy?						
Yes No Has the patient been educated on any contraindications and side effects to therapy?						
☐ Yes ☐ No Has the patient been informed of fertility preservation options before the start of therapy?						
□ Yes □ No Is the requested drug prescribed for gender dysphoria in an adolescent patient?						
Please indicate the Tanner stage of puberty the patient has reached:						
🗌 Tanner stage I 📋 Tanner stage II 📋 Tanner stage III 📋 Tanner stage IV 📋 Tanner stage V 📋 Unknown						
Primary hypogonadism	ypogonadotropic hypogonadism 🛛 🛛	\ge-related hypogonadism 🔲 Late-o	nset hypogonadism			
Other:						
Yes No Is the patien	t currently receiving the requested drug the	rough samples or a manufacturer's patie	ent assistance program?			
Please indicate the patient's gender: 🔲 Biologic male or a person that self identifies as male 📃 Female						
Yes No Before the s	tart of therapy, did the patient have at lea	ast two confirmed low morning serum tota	al testosterone concentrations based on			
reference la	b range or current practice guidelines?					
H. ACKNOWLEDGEMENT						
Request Completed By (Signat	ure Required):		Date: / /			
any insurance company by provid		ceals material information for the purp	th the intent to injure, defraud or deceive pose of misleading, commits a fraudulent			

The plan may request additional information or clarification, if needed, to evaluate requests.