CLEAR FORM

PRIOR AUTHORIZATION CHECKLIST

JATENZO® (testosterone undecanoate) CIII Prescription Referral Form

Phone: 832-365-3420 **Fax:** 855-595-2955
NPI: 1710611686

1. Patient Information

Please fax form and all insurance cards (prescription and medical)

PATIENT NAME (LAST, FIRST)	DOB	GENDER ☐ M ☐ F	HEIGHT	WEIGHT

ALLERGIES	PREFERRED LANGUAGE ☐ English ☐ Spanish ☐ Other:

HEARING IMPAIRED ☐ No ☐ Yes	PHONE	EMAIL

ADDRESS	CITY	STATE	ZIP

2. Diagnosis/Clinical Information

Please fax clinical notes, labs and tests with prescription

Diagnosis

- ☐ E29.1 Testicular hypofunction
  - ☐ Primary Hypogonadism
  - ☐ Secondary Hypogonadism
- ☐ E34.9 Endocrine disorder
  - ☐ Primary Hypogonadism
  - ☐ Secondary Hypogonadism
- ☐ Q98.4 Klinefelter syndrome
- ☐ Z51.81 Encounter for therapeutics drug level monitoring
- ☐ Other: _____

Symptoms to Support TRT:

- ☐ M62.89 Muscle loss
- ☐ R53.83 Other fatigue
- ☐ N50.0 Atrophy of testis
- ☐ R68.82 Decreased libido
- ☐ N52.9 Erectile dysfunction
- ☐ R89.1 Abnormal levels of hormones in specimen from other organ/tissue type:
  - ☐ Thyroid ☐ HIV
  - ☐ Diabetes ☐ Obesity
  - ☐ Other: _____

Reason for Oral Therapy

- ☐ F40.231 Fear of injections
- ☐ D75.1 Secondary polycythemia
- ☐ T49.8X5 Adverse effect of other topical
- ☐ L25.1 Unspecified contact dermatitis due to drugs in contact with skin
- ☐ T38.7X5A Adverse effect of androgens and anabolic congeners, initial encounter
- ☐ Z91.89 Other specified personal risk factors, not elsewhere classified (For instance, risk of transference to other family members)
- ☐ Other: _____

☐ 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 naive

Testosterone Type	Drug Name	Dates Used
☐ Gel		
☐ Injection		
☐ 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☐ Pretreatment levels have been archived or are not available, as the patient was diagnosed by another provider.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 **855-595-2955**

If Calling In the Prescription: Call **832-365-3420** to speak with the pharmacist on duty. **If no answer:** Please leave a message with the prescription information.

If eScripting Prescriptions:

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

1. **Allied Pharmacy**
   1201 Creekway Dr., STE C
   Sugar Land, TX 77478

–OR–

2. NPI: **1710611686**

4. Provider Information

☐ **I authorize Allied Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization/Appeal (PA) process, nursing services, and patient assistance program. I understand THIS IS NOT A PRESCIPTION and provides permission for the network pharmacy to process the PA.**

IMPORTANT NOTICE: This fax is intended to be delivered to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error, and then destroy this document immediately.

▶ Physician Signature: Date:

Clinic Name: Clinic Phone: Clinic Fax:

Clinic Address: City: State: Zip: