

JATENZO® (testosterone undecanoate) CIII Prescription Referral Form



Phone: 860-656-6229 **Fax:** 860-968-0013
NPI: 1952061939

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

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: _____	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: _____	Prior Failed Treatments: Must be completed for all patients ☐ Treatment naive <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Testosterone Type</th> <th style="width: 40%;">Drug Name</th> <th style="width: 35%;">Dates Used</th> </tr> </thead> <tbody> <tr> <td>☐ Gel</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>☐ Injection</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>☐ Nasal</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>☐ Oral</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>☐ Patch</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>☐ Implant</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>☐ Other:</td> <td colspan="2">_____</td> </tr> </tbody> </table>	Testosterone Type	Drug Name	Dates Used	☐ Gel	_____	_____	☐ Injection	_____	_____	☐ Nasal	_____	_____	☐ Oral	_____	_____	☐ Patch	_____	_____	☐ Implant	_____	_____	☐ Other:	_____				
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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: _____																													
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This form alone is NOT A VALID PRESCRIPTION

If Faxing Prescriptions: Fax to 860-968-0013 If Calling In the Prescription: Call 860-656-6229 to speak with the pharmacist on duty. If no answer: Please leave a message with the prescription information.	If eScripting Prescriptions: Add Lush Pharmacy to your EMR system using the following information: <table border="0"> <tr> <td>1. Lush Pharmacy 55 Isham Road West Hartford CT 06107</td> <td>–OR–</td> <td>2. NPI: 1952061939</td> </tr> </table>	1. Lush Pharmacy 55 Isham Road West Hartford CT 06107	–OR–	2. NPI: 1952061939
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☐ I authorize Lush 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 PRESCRIPTION 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: