

JATENZO® (testosterone undecanoate) CIII
Prescription Referral Form

ahma^(rx) Garfield, NJ
Phone: 862-225-9422 Fax: 862-225-9423
NPI: 1053737700

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: 30%;">Testosterone Type</th> <th style="width: 35%;">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>_____</td> <td>_____</td> </tr> </tbody> </table> Testosterone Lab Results: Must be completed for all patients ☐ Pretreatment levels have been archived or are not available, as the patient was diagnosed by another provider.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.	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: _____	☐ 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																									
Pre-Treatment Levels Must have two morning labs prior to treatment with lab levels below normal range <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Date</th> <th style="width: 25%;">Level</th> <th style="width: 50%;">Testosterone Type</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td></td> <td>☐ Total ☐ Free</td> </tr> <tr> <td>2.</td> <td></td> <td>☐ Total ☐ Free</td> </tr> </tbody> </table> Existing TRT Patient Must have lab showing levels outside the normal range <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Date</th> <th style="width: 25%;">Level</th> <th style="width: 50%;">Testosterone Type</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td></td> <td>☐ Total ☐ Free</td> </tr> </tbody> </table>			Date	Level	Testosterone Type	1.		☐ Total ☐ Free	2.		☐ Total ☐ Free	Date	Level	Testosterone Type	1.		☐ Total ☐ Free									
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This form alone is NOT A VALID PRESCRIPTION

If Faxing Prescriptions: Fax to 862-225-9423 If Calling In the Prescription: Call 862-225-9422 to speak with the pharmacist on duty. If no answer: Please leave a message with the prescription information.	If eScripting Prescriptions: Add ahmaRx to your EMR system using the following information: <table border="0"> <tr> <td>1. ahmaRx 85 Outwater Lane Garfield, NJ 07026</td> <td>–OR–</td> <td>2. NPI: 1053737700</td> </tr> </table>	1. ahmaRx 85 Outwater Lane Garfield, NJ 07026	–OR–	2. NPI: 1053737700
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☐ I authorize ahmaRx 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: