Aveed

(*testosterone undecanoate)*

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call
(800) 882-4462 (800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:

☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:

☐ Aveed 750mg/3ml (injection)

Dose: Frequency of therapy: Duration of therapy:

What is your patient's current treatment plan (include target dose and titration plan)?

Please provide clinical support for requesting this DOSE and/or QUANTITY for your patient (examples include past medications tried, pertinent patient history, etc).

Where will this medication be obtained?

☐ CVS Caremark
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Diagnosis related to use: ICD10:

☐ Hypogonadism in Males [Testicular Hypofunction/Low Testosterone with Symptoms]
☐ Gender-Dysphoric/Gender-Incongruent Persons
☐ Undergoing Female-To-Male (FTM) Gender Reassignment (i.e., Endocrinologic Masculinization)
☐ To Enhance Athletic Performance

☐ other (please specify):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy". ☐ new start ☐ continuation of therapy

(if continuation of therapy) Does the patient have documentation of a beneficial clinical response? ☐ Yes ☐ No

(if Hypogonadism) **Is your patient male? ☐ Yes ☐ No

(if Hypogonadism) While taking this drug, will your patient also receive another testosterone product?
☐ Yes or Possibly
☐ No

if hypogonadism, if new start

(if hypogonadism, new start) Prior to treatment, did/does your patient have documented persistent signs and symptoms of androgen deficiency (for example depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, and loss of libido)? ☐ Yes ☐ No

(if yes) Please provide those signs or symptoms that your patient is experiencing.

(if hypogonadism, new start) Please provide details for TWO pretreatment serum testosterone levels (date/time of draw and results, including the lab's normal reference range).

(if hypogonadism, new start) Prior to treatment, did your patient have a low serum testosterone level that was drawn in the early morning and is defined as any of the following?
☐ total testosterone level below the laboratory's normal reference range
☐ free testosterone level below the laboratory's normal reference range
☐ none of the above

(if free testosterone) Was free testosterone measured by an equilibrium dialysis assay? ☐ Yes ☐ No

Prior to treatment, did your patient have a **SECOND** low serum testosterone level that was drawn in the early morning **ON A DIFFERENT DAY** and is defined as any of the following?

☐ total testosterone level below the laboratory's normal reference range
☐ free testosterone level below the laboratory's normal reference range
☐ none of the above

(if free testosterone) Was free testosterone measured by an equilibrium dialysis assay? ☐ Yes ☐ No

if Hypogonadism, if Cont Therapy

(if hypogonadism, cont therapy) Are PRE-TREATMENT clinical records available (including lab records of testosterone levels and chart notes documenting signs and symptoms experienced BEFORE starting the requested medication)?

☐ Yes
☐ No (records lost or unable to provide pre-treatment clinical information)

(if yes) Prior to treatment, did/does your patient have persistent pre-treatment signs and symptoms of androgen deficiency (for example depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, and loss of libido)? ☐ Yes ☐ No

(if yes) Please provide those signs or symptoms that your patient is experiencing.

(if yes) Prior to treatment, did your patient have at least ONE pre-treatment serum testosterone (total or free*) measurement, taken in the early morning, which was low, as defined by the normal laboratory reference values? *Free testosterone levels are to be measured by equilibrium dialysis assay. ☐ Yes ☐ No

(if no) Did your patient have a recent serum testosterone (total or free*) measurement which indicates appropriate treatment (testosterone level within normal laboratory reference values) while receiving testosterone replacement therapy? *Free testosterone levels are to be measured by equilibrium dialysis assay. ☐ Yes ☐ No

(if gender dysphoric or incongruent/gender reassignment) Is this drug being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of transgender individuals? ☐ Yes ☐ No

Additional pertinent information *(Please provide clinical rationale, pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.*):

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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