



CLIENT \_\_\_\_\_

DATE \_\_\_\_\_

### PRIOR AUTHORIZATION QUESTIONNAIRE-Androgen: Androgel®

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

**\*\*FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL\*\***

1. Diagnosis (please indicate):

**Males**

- Hypogonadism                       Delayed Puberty
- Other (please specify): \_\_\_\_\_

**Females**

- Postmenopausal metastatic (skeletal) mammary cancer
- Other (please specify): \_\_\_\_\_

2. **New Start**

Drug/Dose Requested: \_\_\_\_\_

**Continuation of Therapy/Switching Therapy**

Drug/Dose Requested: \_\_\_\_\_

If patient is switching therapy, provide prior Drug/Dose: \_\_\_\_\_

***For female patients and for the diagnosis of delayed puberty skip to Question #5.***

3. Patient's most current Total Testosterone Level (date **must** be within the year):

Level (ng/dL): \_\_\_\_\_ Date: \_\_\_\_\_

4. Indicate the patient's main complaint(s) prior to Androgen therapy: \_\_\_\_\_

5. Physician Signature or name of person providing answers \_\_\_\_\_

Physician Comments \_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
P.O. BOX 758  
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:  
**877-526-9906**

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