



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
11900 W. Lake Park Dr.
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:
877-526-9906

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