



CLIENT _____

DATE _____

PRIOR AUTH QUESTIONNAIRE-Androgen: Delatestryl® (testosterone enanthate) Inj.

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

****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

www.restat.com