



CLIENT \_\_\_\_\_

DATE \_\_\_\_\_

**PRIOR AUTH QUESTIONNAIRE-Androgen: Depo® - Testosterone (testosterone cypionate inj.)**

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

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