Testicular Hypofunction
Prescription Referral Form
NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

1 Patient Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

Patient Name: ______________________ Birthdate: ____________ Sex: Male Female Height: ______ Weight: ______ lbs. kg.

Allergies: ______________________________________ Patient Primary Language: English Spanish Other: _________________

Patient Phone: ___________________________ Caregiver Name: ______________________________________ Hearing Impaired

Patient Address: ____ City: ____________________ State: ______ Zip: ___________

Xyosted Steady Care (copay card) Consent must be filled out completely.

Driver's License Number: ______________

Driver's License State: ________________

Email: ____________________________

Patient consents to enrollment in Xyosted Steady Care Program.

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2 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs, & Tests with the prescription to expedite Prior Authorization.

Check all that apply. Be sure to complete the information on the right-hand side.

Diagnosis:

- E29.1 Testicular Hypofunction
- F64.9 Gender Identity Disorder
- Q98.0 Klinefelter Syndrome
- Other: ______________________________

Reason for Autoinjector:

- F40.231 Needle Phobia
- T49.8 Underdosing with Topical TRT
- H54.7 Limited Vision
- R27.8 Lack of Coordination/Dexterity

Symptoms to Support TRT:

- R68.82 Decreased Libido
- M62.89 Loss of Muscle Mass
- N52.9 Erectile Dysfunction
- E28.0 Estrogen Excess
- R29.890 Vertebral Height Loss/Osteoporosis
- R89.1 Abnormal Levels of Hormones in Specimen from Other Organ/Tissue:
  - Thyroid
  - Obesity
  - HIV
  - Other: ________________
  - Diabetes

Other Supporting Factors:

- Testosterone Transference Risk to Women & Children
- Orchiectomy (One or Both)

Provider has determined that the alternative treatment options would not be as effective as the prescribed medication, and therefore the requested medication is medically necessary.

Prior Failed Treatments: Must be completed for all patients.

Treatment Type	Drug Name	Dates of Use
Testosterone Gel		
Testosterone IM Injection		
Testosterone Nasal		
Testosterone Patch		
Other: ______________		

Testosterone Lab Results: Must be completed for all patients.

Pre-Treatment Levels *Must have two morning labs prior to treatment with lab levels below normal range*

	Date:	Level:	Testosterone Type:
1			Total Testosterone Free Testosterone
2			Total Testosterone Free Testosterone

Existing TRT Patient *Must have lab showing levels outside the normal range*

	Date:	Level:	Testosterone Type:
1			Total Testosterone Free Testosterone

3 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
XYOSTED® (testosterone enanthate) Injection CIII	50mg/0.5ml Autoinjector 75mg/0.5ml Autoinjector 100mg/0.5ml Autoinjector	**Dose:** Inject SQ in the abdominal region once weekly, rotating site. Other: ______________	4	___
___________	______________	______________	___	___

4 Provider/Prescriber Information

Clinic Name: ________________________________ Provider Name: ________________________________

Provider Phone: ____________________ Provider Fax: ____________________ DEA#: ____________________ NPI#: ____________________

Provider Address: ________________________________ City: ____________________ State: ______ Zip: ___________

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Signature: ______________________________________ Date: ____________________ Dispense as Written (Write "DAW")

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs.

IMPORTANT NOTICE: This fax is intended to be delivered to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.