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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: _____

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

Driver's License Number: _____

Driver's License State: _____

Email: _____

Patient consents to enrollment in Steady Care Program.



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
 - HIV
 - Diabetes
 - Obesity
 - Other: _____

Other Supporting Factors:

- Testosterone Transference Risk to Women & Children
- Orchiectomy (One or Both)
- Poor adherence to dietary requirements with other oral TRT
- Insufficient absorption with topical TRT

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 Naive	Testosterone Type	Drug Name	Dates Used
	Gel	_____	_____
	Intramuscular	_____	_____
	Nasal	_____	_____
	Oral	_____	_____
	Patch	_____	_____
	Implant	_____	_____
	Other:	_____	_____

Testosterone Lab Results:

Must be completed for all patients.

Pretreatment levels have been archived or are not available, as the patient was diagnosed by another provider. Provider attests that patient has low testosterone.

Pre-Treatment Levels

Must have two morning labs prior to treatment with lab levels below normal range

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

Existing TRT Patient

Must have lab showing levels outside the normal range

	Date:	Level:	Testosterone Type:	
1			Total	Free



Prescription Information

This form alone is not a valid prescription.

If Faxing Prescriptions:

Fax to 866.588.0371

If Calling In the Prescription:

1. You may call 888.618.4126 to get in touch with the pharmacist on duty directly.
2. Please leave a message with the prescription information if no answer.

If eScripting Prescriptions:

Add **Sterling Specialty Pharmacy** to your EMR system using the following information:

1. **Sterling Specialty Pharmacy**
1312 Northland Drive, Suite 500
Mendota Heights, MN 55120

OR

2. **NPI: 1225548480**

New York providers are required to send a valid eScript for testosterone therapy per New York state law.



Provider/Prescriber Information

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

Signature: _____ Date: _____

Physician or clinical staff authorized to submit prior authorizations.