SimfaRose
Pharmaceutical Specialties
Your Symphony Of Healthcare • Transition Care Specialist

Testosterone Prior Approval Form

DOCTOR: _____ Date: _____

Patient: _____ DOB: _____

Medication Tried (please circle)	**Date last ordered:**	**ICD 10 Codes (please circle)**
Depo-Testosterone Androderm		Hypogonadism, hypogonadotropic (congenital or acquired)
Androgel Axiron Striant Foresta		Hypogonadism, primary (congenital or acquired) Delayed puberty (males)
Natesto Testim		Other: _____
Vogelxo _____mg Compounded Product		Please include ICD-10 code

Please provide the last 2 labs reports:

Date: _____ Free Testosterone: _____ Total Testosterone: _____

Date: _____ Free Testosterone: _____ Total

Other relevant information:

_____

_____

Provider Signature:_____

***Physician Rx Required**