Reset Form Print Form

Connecticut Department of Public Health AIDS Drug Assistance Program

Provider Certification Prior Authorization Form – Xyosted®

A request for the patient identified below has been made for the dispensing of Xyosted® (testosterone enanthate). The Department of Public Health requires more information before this prescription can be paid by the Connecticut AIDS Drug Assistance Program (CADAP).

Please complete and return via fax to: (855) 461-2759

Patient Information:

Last Name:

First Name:

CADAP ID Number:

Date of Birth: / /

Address:

City:

State:

Home Phone: – –

Cell Phone: – –

Healthcare Provider Information:

Last Name:

First Name:

National Provider Identification (NPI) Number:

Address:

City:

State:

Phone Number: – –

Fax Number: – –

(Form continued on next page.)

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Provider Certification Prior Authorization Form – Xyosted®

Patient's Last Name:

Patient's First Name:

Prescription Information:

Please fill out all questions completely and submit required clinical documentation where noted.

1. Drug Name: Xyosted ® (testosterone enanthate)
2. Drug Strength:
   - ☐ 50 mg/0.5 mL subcutaneous (SQ) solution
   - ☐ 75 mg/0.5 mL SQ solution
   - ☐ 100 mg/0.5 mL SQ solution
3. Directions:

_____

_____

Clinical Requirements:

4. Has the patient tried and failed intramuscular testosterone therapy due to any of the following reasons?
   a. Injection pain ☐ Yes ☐ No
   b. Skin atrophy ☐ Yes ☐ No
   c. Inability to self-administer appropriately ☐ Yes ☐ No

   If **Yes** to questions 4. a., b., or c., provide the dates of the patient's most recent intramuscular testosterone therapy trial and failure.:

   _____

5. Has the patient tried and failed topical testosterone therapy due to any of the following reasons?
   a. Pain at the application site ☐ Yes ☐ No
   b. Topical application is adversely affecting non-prescribed patients ☐ Yes ☐ No
   c. Inability to self-administer appropriately ☐ Yes ☐ No

   If **Yes** to questions 5 a., b., or c., provide the dates of the patient's most recent topical testosterone therapy treatment trial and failure.:

   _____

6. Has the patient been on Xyosted® from a previous payer source (e.g., ADAP, Medicare D, Medicaid, private insurance)? ☐ Yes ☐ No
7. Has the patient continued to be therapeutically stable on Xyosted® therapy? ☐ Yes ☐ No

(Form continued on next page.)

Connecticut Department of Public Health, AIDS Drug Assistance Program

Provider Certification Prior Authorization Form – Xyosted®

Patient's Last Name:												Patient's First Name:											

HEALTHCARE PROVIDER CERTIFICATION: I certify that I am a licensed healthcare provider with prescriptive authority and the information provided on this form is true, accurate, and complete. The issuance of the prescription is in compliance with the utilization criteria outlined on the back of this prior authorization form. I understand that if I provide false, fraudulent, and misleading information, that I face fines and penalties under State law.

Healthcare Provider's Signature ***NPI Number***

Date of Request ***Time of Request***