Xyosted Enrollment Form

VALUE SPECIALTY PHARMACY

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs☐ kg☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
Policy: _____ Group#: _____

Diagnosis

Primary Diagnosis: _____ ICD10: _____
Secondary Diagnosis: _____ ICD10: _____

Clinical Information

Please attach clinical notes, lab results, and supportive documentation to expedite the prior authorization

Serum Total Testosterone Level: _____ Lab Date: _____/_____/_____

What clinical signs and symptoms of hypogonadism does the patient have?

☐ Decrease in energy ☐ Decrease in muscle mass ☐ Fatigue ☐ Hot flashes ☐ Difficulty concentrating ☐ Gynecomastia

☐ Other: _____

If appropriate based on risk factors and age, has the patient been screened for prostate cancer? ☐ Yes ☐ No

Has the patient tried and failed a generic injectable testosterone? ☐ Yes ☐ No

Other important information: _____

_____

_____

Prescription

Medication	
☐ Xyosted™	Due to controlled substance guidelines in Pennsylvania please e-prescribe prescription **Surescript ID#** CPR399619107912458 18 *If exempt from this guideline, please attach prescription copy and fax along with form.*

Is patient new to this therapy: ☐ YES ☐ NO | **Ship to:** ☐ Patient ☐ Office ☐ Other

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
Practice Name: _____ Contact: _____
Address: _____ Phone: _____ Fax: _____
City: _____ State: _____ Zip: _____ Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right. ☐