TFP WELLNESS SYSTEMS
Your Lifetime Pharmacy Solution

Xyosted Enrollment Form
Phone: (813) 871-5161 ext. 34993
Fax: (813) 877-2479
Email: yourteam@tfpspecialty.com

PATIENT INFORMTION (OR ATTACH PATIENT DEMOGRAPHIC SHEET)			
Patient Name:		☐Male ☐Female	Allergies: ☐NKDA
Date of Birth:	SSN:		Weight: ☐kg ☐lb Date:
Address:	City:	State:	Zip:
Phone # (Home):	Work #:	Email (Optional):	

INSURANCE INFORMATION (PLEASE PROVIDE COPIES OF MEDICAL AND PRESCRIPTION CARDS, IF AVAILABLE)		
Primary Insurance:	RX Bin:	RX PCN:
RX Group:	RX ID:	RX Phone:
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SSN:

DIAGNOSIS/MEDICAL INFORMATION ***MUST BE COMPLETED FOR ALL PATIENTS***

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

Diagnosis:
- ☐ E29.1 Testicular Hypofunction
- ☐ Other: _____

Symptoms to Support TRT:
- ☐ R68.82 Decreased Libido
- ☐ M62.89 Loss of Muscle Mass
- ☐ N52.9 Erectile Dysfunction
- ☐ E28.0 Estrogen Excess
- ☐ Z79.890 Hormone Replacement Therapy
- ☐ R29.890 Vertebral Height Loss/Osteoporosis
- ☐ R89.1 Abnormal Levels of Hormones in Specimen from Other Organ/Tissue

Reason for Autoinjector:
- ☐ F40.231 Needle Phobia
- ☐ T49.8 Underdosing with Topical TRT
- ☐ H54.7 Limited Vision
- ☐ Other: _____

_____

Other Supporting Factors:
- ☐ Testosterone Transference Risk to Women & Children
- ☐ Q98.0 Klinefelter Syndrome
- ☐ C62.90 Testicular Cancer Orchiectomy (One or Both)
- ☐ Z91.14 Patient's Other Noncompliance with Medication Regimen
- ☐ Other: _____

_____

_____

Prior Failed Treatments:

Treatment Type	Drug Name	Dates of Use
☐ Testosterone Gel	_____	_____
☐ Testosterone IM Inj.	_____	_____
☐ Testosterone Nasal	_____	_____
☐ Testosterone Patch	_____	_____
☐ Other:	_____	_____

Testosterone Lab Results:

Prior to starting testosterone therapy, did patient have low testosterone confirmed by 2 morning labs on separate days?
☐ Yes ☐ No ****If yes, include lab values with dates in chart.**
If patient is on testosterone therapy, include the above values and most recent lab report with dates (must be within last 6 months).

☐ 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.

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QTY	DIRECTIONS	REFILLS
☐ Xyosted® Testosterone enanthate	☐ 50mg/0.5ml Autoinjector ☐ 75mg/0.5ml Autoinjector ☐ 100mg/0.5ml Autoinjector	☐ **4** ☐ _____	☐ Inject SQ in the abdominal region once weekly, rotating site ☐Other: _____ _____	_____

DELIVERY INSTRUCTIONS

☐ Physician Office ☐ Patient's Home ☐ 1st dose to MD office, Refills to patient's home

PHYSICIANS CONTACT INFORMATION & AUTHORIZATION

Physician's Name:	Office Contact:	Institution:
Phone #:	Fax #:	Specialty:
Address:	City/State/Zip:	
Tax ID:	DEA #:	NPI #:
Physician's Signature:		Date:

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original document. Created: 02/10/2022