



Xyosted Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ 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	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Xyosted™	<input type="checkbox"/> 50 mg <input type="checkbox"/> 75 mg <input type="checkbox"/> 100 mg	Inject 1 pen subcutaneously in the abdominal region once weekly	4	

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

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____ Preferred Method: Phone Fax Email
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Email: _____

My signature below authorizes Restore Rx, Inc. 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 Restore Rx, Inc. 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.

fax referral to: 901-388-0407 | phone: 877-388-0507 | www.restorerx.com