**RYAN WHITE PROGRAM**
**Letter of Medical Necessity (LOMN) for Testosterone Supplementation**
(A LOMN must accompany each prescription)

Date: _____

As the prescribing practitioner treating_____, I intend to place this patient on testosterone supplementation (duration may NOT exceed 12 months). I have educated the patient on the consequences of testosterone supplementation and have explained the risks associated with this therapy, including venous blood clots, increased risk of heart attacks and strokes, worsening of undiagnosed prostate cancer and benign prostatic hyperplasia. Hemoglobin levels must be monitored and documented in the patient chart.

I certify that the patient (mark all that apply):

___has a documented low (<350 ng/dL) testosterone lab level at initiation of therapy or low level of free testosterone.

***OR***

___has a documented history of testosterone therapy but has discontinued therapy for 60 calendar days to re-evaluate levels and still has a documented low (<350 ng/dL) testosterone lab level;

***AND/OR***

___has primary hypogonadism, in which there is low testosterone accompanied by increased follicle-stimulated hormone and increased luteinizing hormone. Common causes include: Klinefelter's syndrome, anorchism, undescended testicles, mumps orchitis, hemochromatosis, injury to testicles, cancer treatment, and normal aging;

***AND/OR***

___has secondary hypogonadism, in which there is low testosterone accompanied by low to normal follicle-stimulated hormone and luteinizing hormone. Common causes include: Kallmann syndrome, pituitary disorders, inflammatory diseases, HIV/AIDS, medications, obesity, and stress-induced hypogonadism;

***AND***

___is physically symptomatic (e.g. malaise, fatigue, lethargy, muscle loss, depression, decreased bone mass or bone mineral density, etc.).

The following restriction is placed on the medications: Maximum dose is ***400 mg per month*** unless clinically indicated per labs. ***Labs (testosterone: total and free, CBC, PSA) must be submitted to the pharmacy with this letter, and if medication is continued, every 6 months thereafter.***

_____ , M.D./D.O.

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|---|---|
| _____ | _____ |
| Print M.D./D.O. name | Florida medical license # (MEO #) |
| _____ | _____ |
| Patient's 10 digit Medicaid # (if applicable) | Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System) |

**Please note:** All questions should be addressed to Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietician, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client files (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.