Testosterone Products Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.
Provider Help Desk: 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for testosterone products. Payment will be considered with documentation of a specific testicular or hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism. Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis. Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for erectile dysfunction, infertility, and age-related hypogonadism will not be considered. Payment will be considered under the following conditions:

1. Patient is male and age 18 or older (or 12 years of age and older for testosterone cypionate)
2. Patient has two (2) morning pretreatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (attach results)
3. Patient has primary hypogonadism or hypogonadotropic hypogonadism (further defined below):
    a. Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following: cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, toxic damage from alcohol or heavy metals
    b. Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency, pituitary-hypothalamic injury from tumors, trauma, or radiation
4. Patient does **not** have:
    a. Breast or prostate cancer

b. Palpable prostate nodule or prostate-specific antigen (PSA) > 4 ng/mL
c. Hematocrit > 50 percent
d. Untreated severe obstructive sleep apnea
e. Severe lower urinary tract symptoms
f. Uncontrolled or poorly controlled heart failure

If criteria for coverage are met, initial authorizations will be given for three months. Requests for continuation of therapy will require the following:

- An updated testosterone level (attach result)
- Documentation the patient has not experienced a hematocrit > 54 percent or an increase in PSA > 1.4 ng/mL in the past 12 months

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

☐ Androderm
☐ Testosterone cypionate
☐ Testosterone enanthate
☐ Testosterone gel 1 percent packets

Nonpreferred

☐ Andogel
☐ Android
☐ Aveed
☐ Axiron
☐ Depo-testosterone
☐ Fortesta
☐ Jatenzo
☐ Natesto
☐ Striant
☐ Testim
☐ Testosterone gel 1.62 percent
☐ Testosterone topical solution
☐ Testred
☐ Methyltestosterone
☐ Vogelxo
☐ Testosterone gel pump
☐ Methistest
☐ Xyosted

Complete for diagnosis of hypogonadism:

☐ Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:
- ☐ Cryptorchidism
- ☐ Bilateral torsion
- ☐ Orchitis
- ☐ Vanishing testes syndrome
- ☐ Orchiectomy
- ☐ Klinefelter's syndrome
- ☐ Chemotherapy
- ☐ Toxic damage from alcohol or heavy metals
- ☐ Other: _____

☐ Hypogonadotropic Hypogonadism:
- ☐ Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency
- ☐ Pituitary-hypothalamic injury from tumors, trauma or radiation

Please indicate setting in which medication is to be administered:_____

List and attach results of two morning pretreatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used:

Level 1: _____ Date:_____
Level 2: _____ Date:_____

Does patient have any of the following?

- Breast or prostate cancer: ☐ Yes ☐ No
- Palpable prostate nodule or prostate-specific antigen (PSA) > 4 ng/mL: ☐ Yes ☐ No
- Hematocrit > 50 percent: ☐ Yes ☐ No
- Untreated severe obstructive sleep apnea: ☐ Yes ☐No
- Severe lower urinary tract symptoms: ☐ Yes ☐ No
- Uncontrolled or poorly controlled heart failure: ☐ Yes ☐ No

Renewal requests:
List and attach updated testosterone level: Level: _____ Date: _____

Has patient experienced the following in the past 12 months?
Hematocrit > 54 percent: ☐ Yes ☐ No
Most recent lab date: _____
Increase in PSA > 1.4 ng/mL: ☐ Yes ☐ No
Most recent lab date: _____
Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.