2020 Topical Testosterone Prior Authorization Request

(You must complete both pages.)

Fax completed form to: 1-800-408-2386 **For urgent requests, please call: 1-800-414-2386**

Coverage Criteria for Androderm patch and testosterone topical solution:

- Medication is covered when being prescribed for gender dysphoria in transgender male patients or replacement therapy in male members (or a member that self-identifies as male) for conditions associated with a deficiency or absence of endogenous testosterone such as primary hypogonadism or hypogonadotropic hypogonadism.
  AND
- **For Hypogonadism:**
  - **For therapy initiation:** the member must have at least TWO (2) confirmed low testosterone levels according to current practice guidelines or the standard male lab reference values
  - **For continuation of therapy:** the member must have had a confirmed low testosterone level according to current practice guidelines or the standard male lab reference values before starting testosterone therapy.
- **For gender dysphoria in transgender male patients:**
  - The member must be able to make a mature, informed decision to engage in therapy

Authorization duration: Through end of plan contract year.

Patient information		**Prescriber information**	
Patient name		Today's date	Physician specialty
Patient insurance ID number		Physician name	NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP	
Patient home telephone number		M.D. office telephone number	
Gender ☐ Male ☐ Female	Patient date of birth	M.D. office fax number	

Diagnosis and medical information			
Medication requested ☐ Androderm transdermal patch ☐ testosterone 30mg/act solution ☐ Other: ______________________	Strength and route of administration		Frequency
New prescription OR date therapy initiated	Quantity	Day supply	Expected length of therapy

Diagnosis (*Please include all office notes supporting diagnosis.)*

☐ Primary hypogonadism in adult males

☐ Hypogonadotropic hypogonadism in adult males

☐ Gender dysphoria in transgender male patients

☐ Other diagnoses/ICD 10 codes: ______________________

Please check all boxes that apply:

1. ☐ **Patient is stable on current drug(s) and/or current quantity, medication change would likely result in high risk of significant adverse clinical outcomes.**

2. ☐ **All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.**

(continued on page 2)

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Please check all boxes that apply (continued):

3. ☐ Yes ☐ No **For INITIATION of therapy for hypogonadism in a male patient or a patient that self-identifies as male:**
Does the patient have at least two (2) confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values? **If yes, please provide TWO (2) low testosterone levels:**
Testosterone Level: circle one (Total / Free) level ____________ laboratory range _____(low /high/ normal)
Testosterone Level: circle one (Total / Free) level _____ laboratory range _____(low /high/ normal)

4. ☐ Yes ☐ No **For CONTINUATION of therapy for hypogonadism in a male patient or a patient that self-identifies as male:**
Does the patient have a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy? **If yes, please provide ONE (1) low testosterone level:**
Testosterone Level: circle one (Total / Free) level ____________ laboratory range _____(low /high/ normal)

5. ☐ Yes ☐ No **Is the medication requested for gender dysphoria in a transgender male patient who is able to make an informed, mature decision to engage in therapy?**

6. ☐ Yes ☐ No **The quantity limit for Androderm patch is 30 patches per 30 days and the quantity limit for testosterone solution is 180 ml per 30 days.**
Does the patient require a higher dosage (quantity limit exception)?
►If **YES**, indicate quantity requested: ____________ per 30 days **OR** quantity ____________ per day
☐ The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.
☐ The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

7. ☐ **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

8. ☐ **Other supporting information**
*NOTE: All exception requests require prescriber supporting statements. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

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I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	**Date**

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