PriorityHealth

Medical Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Aveed® (testosterone undecanoate)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Aveed 750 mg/3mL

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose: _____

Dose:_____**Dose Frequency**:_____

ICD-10 Diagnosis code(s): _____

Place of administration:
☐ Self-administered
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Facility: _____ NPI:_____ Fax:_____

Billing:
☐ Patient to obtain from pharmacy
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 05/2018
Last reviewed 01/2021

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Patient is hypogonadal, as evidenced by both of the following:
    a. Clinical signs and symptoms consistent with androgen deficiency (requests for coverage to treat fatigue and decreased libido with no other symptoms is not a covered benefit), and
    b. A serum total testosterone test result of 300 ng/dL or less on two different dates in the previous 12 months (lab results must be included or faxed with request)
2. Must first try generic injectable testosterone, either testosterone enanthate or testosterone cypionate (e.g. testosterone enanthate 150 to 200 mg every two weeks) for a minimum of two months with failure to improve symptoms and failure to increase total serum testosterone above 300ng/dL. If patient experiences fluctuations in energy, mood, or libido, after two months or more, the dosage can be changed (e.g. testosterone enanthate 100 mg once a week).
3. After a trial with generic injectable testosterone, must then first try generic topical testosterone for a minimum of two months with failure to improve symptoms and failure to increase total serum testosterone above 300ng/dL
4. Men age 50 and older (or 40 and older for men with a family history or are African-American) should be screened for prostate cancer before starting therapy and routinely while on therapy

Or

1. Patient has been diagnosed with Gender Dysphoria and documentation of diagnosis submitted to Priority Health.
2. Must have first tried generic injectable testosterone, either testosterone enanthate or testosterone cypionate.
3. After a trial with generic injectable testosterone, must have then first tried generic topical testosterone.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Hypogonadism
☐ Gender Dysphoria
☐ Other – the patient's condition is: _____

B. What clinical signs and symptoms consistent with androgen deficiency does the patient have?

_____
_____

C. List the patient's serum total testosterone (free plus protein-bound) in the 12 months prior to starting testosterone replacement therapy.

☐ Yes
1. Date of lab: _____ Result: _____
2. Date of lab: _____ Result: _____

☐ No – rationale for use: _____

D. List the patient's trials with generic injectable testosterone:

Drug	Dose	Dates of Use	Therapy Outcome

E. List the patient's trials with topical testosterone:

Drug	Dose	Dates of Use	Therapy Outcome

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 05/2018
Last reviewed 01/2021

F. If the patient is 40 years or older with a family history of prostate cancer, 40 years and older and African-American, or age 50 and older, has he been screened for prostate cancer?

- ☐ Yes
- ☐ No, patient does not meet screening criteria
- ☐ No – rationale for use: _____

Additional Information

Injectable testosterone enanthate (Delatestryl) and testosterone cypionate (Depo-Testosterone) do not require prior authorization.

Patients are responsible for a copayment for each one-month supply of drug. Starting four weeks after the first injection, each additional injection is a 10-week supply. The patient is responsible for two copayments for each vial dispensed.

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