Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial** ☒ **Commercial Individual (PPACA)** ☐ **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. The standard review time averages between 1 and 3 business days.

Striant® (testosterone)

Reset Form

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

Drug product: ☐ Striant 30 mg buccal tablet

Date of last dose (if applicable): _____

Dosing frequency: _____

Start date (or date of next dose): _____

Precertification Requirements

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

1. Patient is male
2. Patient is hypogonadal,, as evidenced by both of the following:
   - Clinical signs and symptoms consistent with androgen deficiency (requests for coverage to treat decreased libido with no other symptoms is not a covered benefit), and
   - 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)
3. Must first try injectable testosterone (e.g. testosterone enanthate 150 to 200 mg every two weeks) for a minimum of two months. 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).
4. After a trial with injectable testosterone, must first try Androgel or Axiron.
5. 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

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2016

Last reviewed 01/2017

Note: Authorization for indications 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 drug's use for the identified indication.

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ Hypogonadism
- ☐ Other – rationale for use: _____

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

_____

_____

C. Does the patient have subnormal serum total testosterone (free plus protein-bound) on more than one occasion in the previous 12 months (defined as less than 500 ng/dL for men younger than 60 years, or less than 300 ng/dL for men age 60 and older)?

- ☐ Yes
  1. Date of lab: _____ Result: _____
  2. Date of lab: _____ Result: _____
- ☐ No – rationale for use: _____

D. Has the patient used injectable testosterone (e.g. testosterone enanthate 150 to 200 mg) for at least two months?

- ☐ Yes
- ☐ No , other: _____

E. 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.

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Last reviewed 01/2017