PriorityHealth

Pharmacy 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.

Testosterone topical (generic)

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

☐ New request ☐ Continuation request

Drug product:

- ☐ Testosterone 1% gel pump
- ☐ Testosterone 25 mg/2.5 gm gel
- ☐ Testosterone 50 mg/5 gm gel
- ☐ Testosterone topical solution
- ☐ Testosterone 1.62% gel

Start date (or date of next dose): ______________

Date of last dose (if applicable): ______________

Dosing frequency: ______________

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 or 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) prior to treatment
2. Must first try injectable testosterone (e.g. testosterone enanthate 150 to 200 mg every two weeks) for a minimum of two months with failure to improve symptoms. 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. 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
4. Before topical testosterone solution or topical testosterone 1.62% are covered, must try topical testosterone 1% gel for a minimum of two months.

Or

1. Patient has been diagnosed with Gender Dysphoria and documentation of diagnosis submitted to Priority Health.
2. Must first try injectable testosterone
3. Before topical testosterone solution or topical testosterone 1.62% are covered, must try topical testosterone 1% gel for a minimum of two months.

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

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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.

Priority Health Precertification Documentation

A. What condition is this drug being used for?

- ☐ Hypogonadism
- ☐ Gender Dysphoria
- ☐ 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 less than 300 ng/dL)?

- ☐ 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 , rationale for use: ______________________

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: ______________________

F. If requesting topical testosterone solution or topical testosterone 1.62% gel, has the patient used topical testosterone 1% gel for at least two months?

- ☐ Yes
- ☐ No , rationale for use: ______________________

Additional Information

Injectable testosterone enanthate (Delatestryl) and testosterone cypionate (Depo-Testosterone) do not require prior authorization. “Needle phobia” or “needle fatigue” is not considered an intolerance or contraindication to injectable testosterone therapy.