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2019 Topical Testosterone Prior Authorization Request

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(You must complete both pages.)

Coverage Criteria for Androderm patch and testosterone solution:

Medication is covered when being prescribed for 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 or hypogonadotropic hypogonadism **AND**

- **For therapy initiation:** the member has had at least TWO confirmed low testosterone levels according to current practice guidelines or the standard male lab reference values
- **For continuation of therapy:** the member has had ONE confirmed low testosterone level BEFORE STARTING testosterone therapy according to current practice guidelines or the standard male lab reference values
- **Authorization period**: Through end of plan contract year.

Coverage Criteria for testosterone gel (25mg/2.5gm packet, 50mg/5gm packet) and testosterone pump 1% gel:

Medication is covered when being prescribed for replacement therapy in male members for conditions associated with a deficiency or absence of endogenous testosterone such as primary or hypogonadotropic hypogonadism when not being used solely for muscle building purposes and when being used in the absence of carcinoma of the breast or suspected carcinoma of the prostate **AND**

- **For therapy initiation**:
  1. Member has tried and failed, or has a contraindication or intolerance to generic testosterone gel OR Androderm (testosterone patch) **AND**
  2. Member has had either ONE low total testosterone level **OR** ONE low free testosterone level (below the normal range for the laboratory)
- **For continuation of therapy:** covered for members that are already stabilized on the medication who have tried and failed, or have a contraindication or intolerance to generic testosterone gel **OR** Androderm (testosterone patch) (labs not required)
- Medication is not covered for members with testosterone levels within normal limits prior to initiating therapy.
- **Authorization period**: Through end of plan contract year.

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

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 (preferred) ☐ testosterone 30mg/act solution (preferred) ☐ Other: _____ ☐ testosterone gel 25mg/2.5gm ☐ testosterone gel 50mg/5gm ☐ testosterone gel 1% pump	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.)* ☐ Male hypogonadism ☐ Other diagnosis/(ICD 10): _____			

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Please check all boxes that apply:

1. ☐ **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.**

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

3. ☐ Yes ☐ No **For all requests EXCEPT Androderm and testosterone solution, has the member tried and failed, or does the member have a contraindication or intolerance to generic testosterone gel OR Androderm (testosterone patch)?**

4. ☐ Yes ☐ No **Is this a request for INITIATION of therapy for a male patient with hypogonadism? If yes, please provide TWO testosterone levels for Androderm and testosterone solution requests and ONE testosterone level for all other topical testosterone product requests.**
   Testosterone Level: circle one (Total / Free) level _____ laboratory range _____(low /high/ normal)
   Testosterone Level: circle one (Total / Free) level _____ laboratory range _____(low /high/ normal)

5. ☐ Yes ☐ No **Is this a request for CONTINUATION of therapy for a male patient with hypogonadism? If yes, please provide ONE testosterone level prior to starting therapy for Androderm and testosterone solution requests. No levels are needed for the other topical testosterone product requests.**
   Testosterone Level: circle one (Total / Free) level _____ laboratory range _____(low /high/ normal)

6. **Please review the exclusion criteria below for topical testosterone and check all that apply:**
   - ☐ Patient has testosterone levels within the normal range BEFORE initiating therapy (normal range for the lab doing the testing)
   - ☐ Patient is female
   - ☐ Patient is a male with carcinoma of the breast or suspected carcinoma of the prostate
   - ☐ Medication is being used for muscle building purposes

7. ☐ **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.

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**