TESTOSTERONES PRIOR AUTHORIZATION REQUEST FORM



OptumRx
P.O. Box 25184
Santa Ana, CA, 92799
Phone: (800) 310-6826 Fax: (866) 940-7328





Today's Date					
Note: This form must be completed by the prescribing provider.					
All sections	must be complet	ed or the request	will be returned		
All sections must be completed or the request will be returned Patient's Medicaid # Date of Birth					
Patient's Name Prescriber's Name		ne			
Prescriber's IN License #		Specialty	Specialty		
Prescriber's NPI #		Prescriber's Sigr	Prescriber's Signature		
Return Fax #	Return Fax #		Return Phone #		
Check box if requesting retro-active PA		Date(s) of servic retro-active eligit	e requested for pility (if applicable):		
Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).					
Requested Medication	Strength	Quantity	Dosage Regimen		
DEPO-TESTOSTERONE, TE	STOSTERONE	CYPIONATE			
Initial Authorization:		CYPIONATE			
Initial Authorization: 1. Please select one of the following	:	CYPIONATE			
Initial Authorization: 1. Please select one of the following Member has a diagnosis of o	: delayed puberty		3 months (Documentation is required)		
Initial Authorization: 1. Please select one of the following Member has a diagnosis of o	: delayed puberty		3 months (Documentation is required)		
Initial Authorization: 1. Please select one of the following Member has a diagnosis of o	: delayed puberty one level ≤ 350 ng s none of the follov	/dL within the past ving contraindicatio			
Initial Authorization: 1. Please select one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a total testoster Provider attests that member has Breast cancer in a member has a diagnosis of one of the following of the one of the following of the fo	: delayed puberty one level ≤ 350 ng s none of the follow per assigned male	/dL within the past ving contraindication at birth	ons to therapy: □ Yes □ No		
Initial Authorization: 1. Please select one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a total testoster Provider attests that member has a diagnosis of one of the following Provider attests that member has a diagnosis of one of the following Provider attests that member has a diagnosis of one of the following Provider attests that member has a diagnosis of one of the following Provider attests that member has a diagnosis of one of the following Provider attests that member has a diagnosis of one of the following Provider attests that member has a diagnosis of one of the following Provider attests that member has a diagnosis of one of the following Provider attests that member has a diagnosis of one of the following that a di	: delayed puberty one level ≤ 350 ng s none of the follow per assigned male	/dL within the past ving contraindication at birth	ons to therapy: □ Yes □ No		
Initial Authorization: 1. Please select one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Provider attests that member has a diagnosis of the following Provider attests that member has a diagnosis of the following Provider attests that member has a diagnosis of the following Provider attests that member has a diagnosis of the following Provider attests that member has a diagnosis of the following Provider attests that member has a diagnosis of the following Provider attests that member has a diagnosis of the following Provider attests that member has a diagnosis of the following has	: delayed puberty one level ≤ 350 ng s none of the follow per assigned male adication and medi	/dL within the past ving contraindicatio at birth cal rationale for us	e:		
Initial Authorization: 1. Please select one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Member has a diagnosis of one of the following Provider attests that member has a member has a member has been discovered by the following of	: delayed puberty one level ≤ 350 ng s none of the follow per assigned male adication and medi	/dL within the past ving contraindicatio at birth cal rationale for us	e:		

Reauthorization: 1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) □ Yes □ No
2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
TESTOSTERONE ENANTHATE
Initial Authorization: 1. Please select one of the following:
☐ Member has a diagnosis of delayed puberty
 Has the member had a previous trial and failure of ALL preferred injectable testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
(reference PA criteria)? □ Yes □ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
 Member has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) Has the member had a previous trial and failure of ALL preferred injectable testosterone agents (reference PA criteria)? ☐ Yes ☐ No If no, please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
 ☐ Member needs medication for palliative treatment of metastatic breast cancer 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No • Breast cancer in a member assigned male at birth • Pregnancy
Prostate cancer
If no , please specify contraindication and medical rationale for use:
Note: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply.
Reauthorization: 1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Has the member had a previous trial and failure of at least ONE preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (not required for palliative treatment of breast cancer) [reference PA criteria]? Yes No

If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
3. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above Yes No
If no , please specify contraindication and medical rationale for use:
AVEED TESTORE DELLET YVSOTED
AVEED, TESTOPEL PELLET, XYSOTED Initial Authorization:
Please select one of the following:
\square Member has a diagnosis of delayed puberty
 Has the member had a previous trial and failure of ALL preferred injectable testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria)?
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
 Member has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) Has the member had a previous trial and failure of ALL preferred injectable testosterone agents (reference PA criteria)? ☐ Yes ☐ No If no, please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No • Breast cancer in a member assigned male at birth • Hypogonadal conditions not associated with structural or genetic etiologies (Xyosted ONLY) • Pregnancy • Prostate cancer If no , please specify contraindication and medical rationale for use:
Note: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply
Reauthorization:
1. Total testosterone level is ≤1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Has the member had a previous trial and failure of at least ONE preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria)? Yes No

	testosterone agents:
	vider attests that member remains a candidate for treatment, indicating that they have not developed any of contraindication(s) listed under initial authorization above \square Yes \square No
	If no , please specify contraindication and medical rationale for use:
	RODERM, TESTOSTERONE 1% (25 MG)/ 2.5 GM GEL PACKETS, TESTOSTERONE
•	2.5 MG)/ACT GEL PUMP, TESTOSTERONE 1.62% (20.25 MG)/ACT METERED P GEL, TESTIM 1% (50 MG)/5 GM GEL TUBES
1. Plea	Authorization: ase select one of the following: Member is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required), and is requesting to use topical testosterone within the established quantity limits
	Requested dose:
	Member is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical testosterone therapy (Documentation is required) and is requesting to exceed established quantity limits
	Requested dose:
	Member has utilized ≥ 14 days of topical testosterone therapy: ☐ Yes ☐ No
	Name of medication: Dose:
	Start and End date:
	If no , please provide medical justification as to why member is requesting a dose beyond established quantity limits:
	If no , please provide medical justification as to why member is requesting a dose beyond established
	If no , please provide medical justification as to why member is requesting a dose beyond established quantity limits: ———————————————————————————————————
	If no, please provide medical justification as to why member is requesting a dose beyond established quantity limits: ALL indications: ovider attests that member has none of the following contraindications to therapy: Pregnancy Pregnancy

1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) □ Yes □ No
2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
Note: dose requested for reauthorization should not exceed established quantity limits unless member historically has been approved to exceed the established quantity limits Requested dose:
NATESTO, TESTOSTERONE 1% (50 MG)/5 GM GEL PACKETS/TUBES, TESTOSTERONE 1.62% (40.5 MG)/2.5 GM GEL PACKETS, TESTOSTERONE 1.62% (20.25 MG)/1.25 GM GEL PACKETS, TESTOSTERONE 2% (10 MG)/ACT METERED PUMP, TESTOSTERONE 30 MG/ACT SOLUTION, VOGELXO 1% (50 MG)/5 GM GEL PACKETS, VOGELXO 1% (12.5 MG)/ACT GEL PUMP
Initial Authorization: 1. Please select one of the following: ☐ Member is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required), and is requesting to use topical testosterone within the established quantity limits
Requested dose:
Member is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical testosterone therapy (Documentation is required) and is requesting to exceed established quantity limits Requested dose:
Member has utilized ≥ 14 days of topical testosterone therapy: ☐ Yes ☐ No
Name of medication:
Dose:
Start and End date:
If no , please provide medical justification as to why member is requesting a dose beyond established quantity limits:
2. Previous trial and failure of ALL preferred topical testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) Yes No If no, please provide medical justification for use of requested agent over ALL preferred topical testosterone agents:

Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No ■ Breast cancer in a member assigned male at birth
Breast cancer in a member assigned male at birth
•
Pregnancy
Prostate cancer
If no , please specify contraindication and medical rationale for use:
Note: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply
Reauthorization:
1. Total testosterone level is ≤1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Previous trial and failure of at least ONE preferred topical testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) \square Yes \square No
If no , please provide medical justification for use of requested agent over ALL preferred topical testosterone agents:
3. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above ☐ Yes ☐ No If no, please specify contraindication and medical rationale for use:
Note: dose requested for reauthorization should not exceed established quantity limits unless member historically has been approved to exceed the established quantity limits
Requested dose:
· ————————————————————————————————————
DANAZOL:
· ————————————————————————————————————
DANAZOL:
DANAZOL: Initial Authorization (approval up to 6 months):
DANAZOL: Initial Authorization (approval up to 6 months): 1. Member diagnosis(es): Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia
DANAZOL: Initial Authorization (approval up to 6 months): 1. Member diagnosis(es): Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia 2. For ALL indications:
DANAZOL: Initial Authorization (approval up to 6 months): 1. Member diagnosis(es): Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: Yes No
DANAZOL: Initial Authorization (approval up to 6 months): 1. Member diagnosis(es): Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: Yes No Active or history of thrombosis or thromboembolic disease
Initial Authorization (approval up to 6 months): 1. Member diagnosis(es): Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: • Active or history of thrombosis or thromboembolic disease • Androgen-dependent tumor
DANAZOL: Initial Authorization (approval up to 6 months): 1. Member diagnosis(es): Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: • Active or history of thrombosis or thromboembolic disease • Androgen-dependent tumor • Cardiac disease
DANAZOL: Initial Authorization (approval up to 6 months): 1. Member diagnosis(es): Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: Yes No Active or history of thrombosis or thromboembolic disease Androgen-dependent tumor Cardiac disease Porphyria
DANAZOL: Initial Authorization (approval up to 6 months): 1. Member diagnosis(es): Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: \(\subseteq \text{Yes} \) No • Active or history of thrombosis or thromboembolic disease • Androgen-dependent tumor • Cardiac disease • Porphyria • Pregnancy or breast-feeding
DANAZOL: Initial Authorization (approval up to 6 months): 1. Member diagnosis(es):
DANAZOL: Initial Authorization (approval up to 6 months): 1. Member diagnosis(es): Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: \(\subseteq \text{Yes} \) No • Active or history of thrombosis or thromboembolic disease • Androgen-dependent tumor • Cardiac disease • Porphyria • Pregnancy or breast-feeding

If no , please specify contraindication and medical	rationale for use:
Reauthorization (approval up to 6 months):	
 Documentation from prescriber indicating continued be adverse events ☐ Yes ☐ No 	nefit from the medication without significant
2. Provider attests that member remains a candidate for to the contraindication(s) listed under initial authorization	
If no , please specify contraindication and medical	rationale for use:
	
JATENZO (TESTOSTERONE UNDECANOATE	≣):
Initial Authorization: 1. Member is 18 years of age or older and is requesting to limits	
Requested dose:	□ Yes □ No
 Member has a diagnosis of hypogonadism with a total to (Documentation is required) Yes No Previous trial and failure of at least ONE preferred inject history, chart documentation, or provider attestation included. 	ctable testosterone agent, as confirmed by claims
If no , please provide medical justification for use of testosterone agents:	•
4. For ALL indications: Provider attests that member has none of the following Breast cancer in a member assigned male at Hypogonadal conditions not associated with s Pregnancy Prostate cancer If no, please specify contraindication and medical in	birth structural or genetic etiologies
Reauthorization:	
1. Total testosterone level is ≤ 1000 ng/dL within the past	6 months (Documentation is required) \square Yes \square No
2. Provider attests that member remains a candidate for to the contraindication(s) listed under initial authorization	· · · · · · · · · · · · · · · · · · ·
If no , please specify contraindication and medical i	rationale for use:

3. Previous trial and failure of at least ONE preferred injectable testosterone agent , as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
Note: dose requested for reauthorization should not exceed established quantity limits
Requested dose:
METHITEST (METHYLTESTOSTERONE)
Initial Authorization (approval up to 6 months):
1. Please select one of the following:
☐ Member has a diagnosis of cryptorchidism
☐ Member has a diagnosis of delayed puberty
Member has a diagnosis of hypogonadism (primary or hypogonadotropic) with a total testosterone
≤ 350 ng/dL within the past 3 months (Documentation is required) Member needs medication for palliative treatment of metastatic breast cancer
Interniber neede medication for paintaire treatment of metactatic breast carried
2. Previous trial and failure of at least ONE preferred injectable testosterone agent, as confirmed by claims nistory, chart documentation, or provider attestation including dates of trial (reference PA criteria) \Box Yes \Box No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
3. For ALL indications:
 Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No Breast cancer in a member assigned male at birth Pregnancy Prostate cancer
If no , please specify contraindication and medical rationale for use:
4. Dose requested of methyltestosterone is within the established quantity limits
Requested dose:
Reauthorization (approval up to 6 months):
1. Please select one of the following:
☐ Member has a diagnosis of delayed puberty, palliative treatment of metastatic breast cancer, or

2. For ALL indications:
Provider attests that member remains a candidate for treatment, indicating that they have not developed any
of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:

3. Previous trial and failure of at least ONE preferred injectable testosterone agent, as confirmed by claims
history, chart documentation, or provider attestation including dates of trial (reference PA criteria) \square Yes \square No
If no , please provide medical justification for use of requested agent over ALL preferred injectable
testosterone agents:
Note: dose requested for reauthorization should not exceed established quantity limits
Degree to decease
Requested dose:
TLANDO (TESTOSTERONE UNDECANOATE)
Initial Authorization:
1. Member is 18 years of age or older and is requesting to use oral testosterone within the established quantity
limits
De worded doors
Requested dose:
2. Manch on hear a diagnosis of hymenopodisms and a total testactorum alexal < 250 mg/dl within the next 2 months
2. Member has a diagnosis of hypogonadism and a total testosterone level ≤ 350 ng/dL within the past 3 months
(Documentation is required)
3. Previous trial and failure of at least ONE preferred injectable testosterone agent , as confirmed by claims
history, chart documentation, or provider attestation including dates of trial (reference PA criteria) \square Yes \square No
If no , please provide medical justification for use of requested agent over ALL preferred injectable
testosterone agents:
4. For ALL indications:
Provider attests that member has none of the following contraindications to therapy: \Box Yes \Box No
Breast cancer
 Hypogonadal conditions not associated with structural or genetic etiologies
 Pregnancy
Prostate cancer
If no , please specify contraindication and medical rationale for use:

Reauthorization: 1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) □ Yes □ No
2. Prescriber attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
3. Previous trial and failure of at least ONE preferred injectable testosterone agent , as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) \square Yes \square No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
Note: dose requested for reauthorization should not exceed established quantity limits
Requested dose:

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