CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
TESTOSTERONES PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐ Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ Start Date: _____
Diagnosis	Diagnosis Code

Requested Medication	Strength	Quantity	Directions for Use

DEPO-TESTOSTERONE, TESTOSTERONE CYPIONATE

Initial Authorization:

1. Please select one of the following:
   - ☐ Member has a diagnosis of delayed puberty
   - ☐ Member has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required)

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:

   _____

   _____

Prescriber Signature: _____ **Date:** _____

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 ☐ Yes ☐ No

   If **no**, please specify contraindication and medical rationale for use:

   _____

   _____

Prescriber Signature: _____ Date: _____

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 (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:

   _____

   _____

Prescriber Signature: _____ Date: _____

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 (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:

_____

_____

Prescriber Signature: _____ **Date:** _____

AVEED, TESTOPEL PELLET, XYSOTED

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 (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:

_____

_____

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:

_____

_____

Prescriber Signature: _____ **Date:** _____

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 (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:

_____

_____

Prescriber Signature: _____ Date: _____

TESTOSTERONE 1% (25 MG)/ 2.5 GM GEL PACKETS, TESTOSTERONE 1% (12.5 MG)/ACT GEL PUMP, TESTOSTERONE 1.62% (20.25 MG)/ACT METERED PUMP GEL, TESTIM 1% (50 MG)/5 GM GEL PACKETS

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 therapies □ 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. 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:

_____

_____

Prescriber Signature: _____ Date: _____

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 ☐ Yes ☐ No

   If **no**, please specify contraindication and medical rationale for use:

   _____

   _____

Prescriber Signature: _____ Date: _____

NATESTO, TESTOSTERONE 1% (12.5 MG)/ACT GEL PUMP, 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 therapies: ☐ 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 (reference PA criteria) ☐ Yes ☐ No

   If **no**, please provide medical justification for use of requested agent over ALL preferred topical 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:

_____

_____

Prescriber Signature: _____ Date: _____

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 ☐ Yes ☐ 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:

_____

_____

Prescriber Signature: _____ Date: _____

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
- Pregnancy or breast-feeding
- Severe hepatic disease
- Severe renal disease
- Undiagnosed genital bleeding

If **no**, please specify contraindication and medical rationale for use:

_____

_____

Prescriber Signature: _____ Date: _____

Reauthorization (approval up to 6 months):

1. Documentation from prescriber indicating continued benefit from the medication without significant adverse events ☐ 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 ☐ Yes ☐ No

If **no**, please specify contraindication and medical rationale for use:

_____

_____

Prescriber Signature: _____ Date: _____

JATENZO (TESTOSTERONE UNDECANOATE):

Initial Authorization:

1. Member is 18 years of age or older ☐ Yes ☐ No

2. Member has a diagnosis of hypogonadism with a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) ☐ Yes ☐ No

3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria)

☐ Yes ☐ 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: ☐ Yes ☐ No
   - Breast cancer in a member assigned male at birth
   - Hypogonadal conditions not associated with structural or genetic etiologies
   - Pregnancy
   - Prostate cancer

If **no**, please specify contraindication and medical rationale for use:

_____

_____

Prescriber Signature: _____ Date: _____

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 ☐ Yes ☐ No

If **no**, please specify contraindication and medical rationale for use:

_____

_____

Prescriber Signature: _____ Date: _____

3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria)
☐ Yes ☐ No
If **no**, please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:

_____

_____

KYZATREX (TESTOSTERONE UNDECANOATE):

Initial Authorization:

1. Member is 18 years of age or older ☐ Yes ☐ No

2. Member has a diagnosis of hypogonadism and a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) ☐ Yes ☐ No

3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria)
☐ Yes ☐ 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: ☐ Yes ☐ 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:

_____

_____

Prescriber Signature: _____ Date: _____

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 ☐ Yes ☐ No

If **no**, please specify contraindication and medical rationale for use:

_____

_____

Prescriber Signature: _____ Date: _____

3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria)
☐ Yes ☐ No
If **no**, please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:

_____

_____

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

2. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria)

   ☐ Yes ☐ 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:

   _____

   _____

Prescriber Signature: _____ Date: _____

Reauthorization (approval up to 6 months):

1. Please select one of the following:
   - ☐ Member has a diagnosis of hypogonadism and a total testosterone level ≤ 1000 ng/dL within the past 6 months (Documentation is required)
   - ☐ Member has a diagnosis of delayed puberty, palliative treatment of metastatic breast cancer, or cryptorchidism AND prescriber has submitted documentation indicating continued benefit from the medication without significant adverse events:

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 ☐ Yes ☐ No

   If **no**, please specify contraindication and medical rationale for use:

   _____

   _____

Prescriber Signature: _____ Date: _____

3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria)

   ☐ Yes ☐ No

   If **no**, please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:

   _____

   _____

OXANDRIN (OXANDROLONE):

Initial Authorization (approval up to 6 months):

1. Member diagnosis(es):_____

Note: Approvable diagnoses include adjunct treatment of severe burns during the catabolic and rehabilitative phases, AIDS-associated wasting syndrome, alcoholic hepatitis, cachexia

2. For ALL indications:

Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No

- Breast cancer
- Hypercalcemia
- Pregnancy
- Prostate cancer
- Severe renal disease

If **no**, please specify contraindication and medical rationale for use:

_____

_____

Prescriber Signature: _____ Date: _____

Reauthorization (approval up to 6 months):

1. Documentation from prescriber indicating continued benefit from the medication without significant adverse events ☐ 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 ☐ Yes ☐ No

If **no**, please specify contraindication and medical rationale for use:

_____

_____

Prescriber Signature: _____ Date: _____

TLANDO (TESTOSTERONE UNDECANOATE)

Initial Authorization:

1. Member is 18 years of age or older ☐ Yes ☐ No

2. Member has a diagnosis of hypogonadism and a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) ☐ Yes ☐ No

3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria)

☐ Yes ☐ 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: ☐ Yes ☐ 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:

_____

_____

Prescriber Signature: _____ Date: _____

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 ☐ Yes ☐ No

   If **no**, please specify contraindication and medical rationale for use:

   _____

   _____

   Prescriber Signature: _____ Date: _____

3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria)

   ☐ Yes ☐ No

   If **no**, please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:

   _____

   _____

I attest that the provided information above is accurate:

Physician Signature: _____ Date: _____