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

MDwise
Fax to: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131
Phone: (808) 788-2949

MDwise
A McLaren Company

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

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

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

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (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, 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:

   _____

   _____

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:

_____

_____

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:

_____

_____

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:

_____

_____

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:

_____

_____

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:

_____

_____

ANDRODERM, 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 TUBES

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. 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:

_____

_____

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:

_____

_____

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 (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:

_____

_____

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:

_____

_____

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:_____

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

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

_____

_____

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:

_____

_____

JATENZO (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**

   Requested dose:_____ ☐ 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:

   _____

   _____

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:

   _____

   _____

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:

   _____

   _____

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

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:

   _____

   _____

4. Dose requested of methyltestosterone is **within the established quantity limits**

   Requested dose:_____ ☐ Yes ☐ No

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:

   _____

   _____

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:

   _____

_____

Note: dose requested for reauthorization should not exceed established quantity limits

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**

   Requested dose:_____ ☐ 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:

   _____

   _____

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:

   _____

   _____

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:

   _____

   _____

Note: dose requested for reauthorization should not exceed established quantity limits

Requested dose:_____

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