1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Androgens Prior Authorization Request Form (Page 1 of 3)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Delayed puberty [**Android, Androxy, Methitest, methyltestosterone,** and **Testred** only]
❑ Gender Identity Disorder
❑ Hypogonadism
❑ Inoperable breast cancer, palliative treatment [**Android, Androxy, Methitest, methyltestosterone,** and **Testred** only]
❑ Other diagnosis:_____ICD-10 Code(s): _____

Continuation of therapy:
Is this a continuation of testosterone therapy? ❑ **Yes** ❑ **No**

Which gender was the patient at birth? (Select from one of the options below)
❑ Female
❑ Male

Medication History:

Select the medications the patient has a failure, contraindication, or intolerance to:
❑ Androderm (testosterone patch)
❑ Androgel 1% (testosterone gel)
❑ Androgel 1.62% gel (testosterone gel)
❑ Androgel 1.62% pump (testosterone pump)
❑ Fortesta (testosterone gel)
❑ Testim (testosterone gel)

Hypogonadism in men:

Does the patient have a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? ❑ **Yes** ❑ **No**

Does the patient have a history of one of the following: Bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)? ❑ **Yes** ❑ **No**

Laboratory information:

Total testosterone level:

Does the patient have two pre-treatment serum total testosterone levels less than 280ng/dL (< 9.7 nmol/L) or less than the reference range for the lab? ❑ **Yes** ❑ **No**

Calculated free or bioavailable testosterone level:

Does the patient have one pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (< 0.17 nmol/L) or less than the reference range for the lab? ❑ **Yes** ❑ **No**

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Gender Identity Disorder:

Is the patient using hormones to change physical characteristics? ❑ **Yes** ❑ **No**

Does the patient have demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks? ❑ **Yes** ❑ **No**

Does the patient have a documented real-life experience (living as the other gender) of at least three months prior to the administration of hormone? ❑ **Yes** ❑ **No**

Has the patient had a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months)? ❑ **Yes** ❑ **No**

Is the patient a female-to-male transsexual**?** ❑ **Yes** ❑ **No**

Does the patient meet the definition of Gender Identity Disorder characterized by the following? ❑ **Yes** ❑ **No**

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex
- The disturbance is not concurrent with a physical intersex condition
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The transsexual identity has been present persistently for at least two years
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is the patient's follow-up **total serum** testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy within or below the normal limits of the reporting lab? ❑ **Yes** ❑ **No**

Is the patient's follow-up **total serum** testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy outside of the upper limits of normal for the reporting lab and the dose has been adjusted? ❑ **Yes** ❑ **No**

Is the patient's follow-up **calculated free or bioavailable** testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy within or below the normal limits of the reporting lab? ❑ **Yes** ❑ **No**

Is the patient's follow-up **calculated free or bioavailable** testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy outside of the upper limits of normal for the reporting lab and the dose has been adjusted? ❑ **Yes** ❑ **No**

Does the patient have a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

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I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	