PRO ACT
PHARMACY BENEFIT MANAGEMENT

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

# Depo-Testosterone® (testosterone cypionate)
# 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:**

❑ Female-to-male transsexual -gender identity disorder
❑ Hypogonadotropic hypogonadism (congenital or acquired)
❑ Primary hypogonadism (congenital or acquired)
❑ Other diagnosis:_____ICD-10 Code(s): _____

**For female-to-male transsexual - gender identity disorder, answer the following:**

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**

Is there documentation the patient has had real-life experience (living as the other gender) for at least 3 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 3 months)? ❑ **Yes** ❑ **No**

Does the patient have characteristics that meet the definition of gender identity disorder (see characteristics listed below)? ❑ **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 chromosomal abnormality

**For male hypogonadism, answer the following:**

Was the patient a male at birth? ❑ **Yes** ❑ **No**

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

Please document two pre-treatment serum total testosterone levels and the reference ranges for the lab:

Total testosterone level:_____Reference range:_____Date taken: _____
Total testosterone level:_____Reference range:_____Date taken: _____

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

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**

Please document the pre-treatment calculated free or bioavailable testosterone level and the reference range for the lab:

Free testosterone level:_____Reference range:_____Date taken: _____

Select if the patient has history of the following:

- ❑ Bilateral orchiectomy
- ❑ Panhypopituitarism
- ❑ A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

**Reauthorization:**

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

Does the patient have a follow-up total serum testosterone level drawn from within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy that is **within or below** the normal limits of the reporting lab? ❑ **Yes** ❑ **No**

Please document the serum total testosterone level and the reference ranges for the lab:

Current total testosterone level:_____Reference range:_____Date taken: _____

Does the patient have a follow-up total serum testosterone level drawn from within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy that is **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, diabetes, obesity)? ❑ **Yes** ❑ **No**

Does the patient have a follow-up calculated free or bioavailable testosterone level drawn from within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy that is **within or below** the normal limits of the reporting lab? ❑ **Yes** ❑ **No**

Please document the free/bioavailable testosterone level and the reference ranges for the lab:

Current free/bioavailable testosterone level:_____Reference range:_____Date taken: _____

Does the patient have a follow-up calculated free or bioavailable testosterone level drawn from within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy that is **outside** of upper limits of normal for the reporting lab **AND** the dose has been adjusted? ❑ **Yes** ❑ **No**

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**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.**

**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: | |