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

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

For delayed puberty, answer the following:

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

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 offunctioning
- 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

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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:_____

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 for gender identity disorder or male hypogonadism, 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**

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:	