

Indiana Health Coverage Programs (IHCP)

Testosterones Prior Authorization Request Form

Humana Healthy Horizons® in Indiana – Indiana PathWays for Aging, P.O. Box 14601
 Lexington, KY 40512-4601
 Phone: 800-555-2546 Fax: 877-486-2621

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 # <input style="width: 100%;" type="text"/>	Date of birth <input style="width: 100%;" type="text"/>
Patient's name <input style="width: 100%;" type="text"/>	Prescriber's name <input style="width: 100%;" type="text"/>
Prescriber's IN license # <input style="width: 100%;" type="text"/>	Specialty <input style="width: 100%;" type="text"/>
Prescriber's NPI # <input style="width: 100%;" type="text"/>	Prescriber's signature <input style="width: 100%;" type="text"/>
Return fax # <input style="width: 25%;" type="text"/> <input style="width: 25%;" type="text"/> <input style="width: 25%;" type="text"/> <input style="width: 25%;" type="text"/>	Return phone # <input style="width: 25%;" type="text"/> <input style="width: 25%;" type="text"/> <input style="width: 25%;" type="text"/> <input style="width: 25%;" type="text"/>
Check box if requesting retro-active PA <input type="checkbox"/>	Date(s) of service requested for retro-active eligibility (if applicable): <input style="width: 100%;" type="text"/>

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 and strength	Dosage	Treatment duration



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: _____

Note: *If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and switching formulations to preferred injectable formulation, reauthorization criteria will apply.*

Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six 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, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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 three 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: _____

Note: *If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply.*

Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six months (Documentation is required)

Yes No

2. Has the member had a previous trial and failure of at least one preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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: _____

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, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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 \leq 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: _____

Note: *If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply.*

Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six months (Documentation is required)
 Yes No

2. Has the member had a previous trial and failure of at least one preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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: _____

Testosterone 1% (25 mg)/ 2.5 gm gel packets, Testosterone 1% (50 mg)/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 three months (Documentation is required), and is requesting to use topical testosterone within the established quantity limits Yes No

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 Yes No

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: _____

Note: *If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply.*

Reauthorization:

Total testosterone level is \leq 1000 ng/dL within the past six 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 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 three months (Documentation is required), and is requesting to use topical testosterone within the established quantity limits Yes No

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 Yes No

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, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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: _____

Note: *If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply.*

Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six months (Documentation is required)

Yes No

2. Previous trial and failure of at least one preferred topical testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) 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: _____

Danazol:

Initial authorization:

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 six 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 Yes No
Requested dose: _____
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, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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 cancerIf no, please specify contraindication and medical rationale for use: _____

Reauthorization: (approval up to six months):

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, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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:

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 three 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, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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 six 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 six 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, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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 Yes No
Requested dose: _____
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, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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 cancerIf no, please specify contraindication and medical rationale for use: _____

Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six 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, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (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: _____

Undecatrex (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 Yes No
Requested dose: _____
2. Member has a diagnosis of hypogonadism with a total testosterone level ≤ 350 ng/dL within the past three months (Documentation is required) Yes No
3. Previous trial and failure of both Jatenzo AND Tlando, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) Yes No
If no, please provide medical justification for use of requested agent over Jatenzo and Tlando:

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 cancerIf no, please specify contraindication and medical rationale for use: _____

Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six 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 both Jatenzo AND Tlando, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) Yes No
If no, please provide medical justification for use of requested agent over Jatenzo and Tlando:

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

Requested dose: _____

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