Indiana Health Coverage Programs (IHCP) Testosterones Prior Authorization Request Form

Humana Healthy Horizons , P.O. Box 14601, Lexington, KY 40512-4601 Phone: 800-555-2546 Fax: 877-486-2621						
Today's Date / / /	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 N	ame			
Prescriber's IN License #		Specialty				
Prescriber's NPI #		Prescriber's Si	gnature			
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 Stre	ength	Quantity	Dosage Regimen			
DEDO TESTOSTEDONE TESTOSTEDON	E CYDIONA	TC				
DEPO-TESTOSTERONE, TESTOSTERON Initial Authorization:	ECTPIONA	ic.				
1. Please select one of the following:						
☐ Member has a diagnosis of delayed puberty						
☐ Member has a total testosteron	e level ≤ 35	0 ng/dL within	the past 3 months			
(Documentation is required)						
2. For ALL indications: Provider attests that member has r	one of the	following contr	raindications to therapy:			
Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No						





DEPO-TESTOSTERONE, TESTOSTERONE CYPTONATE	
Breast cancer in a member assigned male at birthPregnancyProstate cancer	
If no , please specify contraindication and medical rati	onale for use:
Note: If member has had history with injectable/topical proclaims history, and switching formulations to preferred injustil apply.	
Reauthorization:	
1. Total testosterone level is ≤ 1000 ng/dL within the pas☐ Yes ☐ No	t 6 months (Documentation is required)
 Provider attests that member remains a candidate for developed any of the contraindication(s) listed under in If no, please specify contraindication and medical ratio 	nitial authorization above Yes No
ir no , please specify contrainal cation and medical ratio	mule 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 agents, as confirmed by claims history, chart docu including dates of trial (reference PA criteria)? 	mentation, or provider attestation
If no , please provide medical justification for use of retestosterone agents:	
	within the past 3 months
 Has the member had a previous trial and failure of agents (reference PA criteria)? 	ALL preferred injectable testosterone
If no , please provide medical justification for use of retestosterone agents:	
☐ Member needs medication for palliative treatmen	t of metastatic breast cancer
ember needs medication for pathative treatment	t of filetastatic bicast carical

TE	STOSTERONE ENANTHATE
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:
CO	ote: If member has had history with injectable/topical product within the past 120 days, infirmed by claims history, and are switching formulations to nonpreferred injectable formulation, authorization criteria will apply.
Re	eauthorization:
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, 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:
	/EED, AZMIRO, TESTOPEL PELLET, XYSOTED
	itial 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)?
	If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:

AVE	ED, AZMIRO, TESTOPEL PELLET, XYSOTED
	\Box Member has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation s required)
•	Has the member had a previous trial and failure of ALL preferred injectable testosterone agents (reference PA criteria)? Yes No
	no , please provide medical justification for use of requested agent over ALL preferred injectable estosterone agents:
F	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
1t —	no , please specify contraindication and medical rationale for use:
conf	e: If member has had history with injectable/topical product within the past 120 days, firmed by claims history, and are switching formulations to nonpreferred injectable formulation, uthorization criteria will apply
Rea	uthorization:
	Total testosterone level is ≤1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
(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)?
	no , please provide medical justification for use of requested agent over ALL preferred injectable estosterone agents:
	Provider attests that member remains a candidate for treatment, indicating that they have not leveloped any of the contraindication(s) listed under initial authorization above Yes No
If	no , please specify contraindication and medical rationale for use:
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ANDRODERM, 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:

L.	Please select one of the following:
	\Box 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 \Box Yes \Box No
	Requested does:
	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 does:
	Member has utilized ≥ 14 days of topical testosterone therapy ☐ Yes ☐ No
	Name of medication:
	Does:Start and End date:
	If no , please specify contraindication and medical rationale for use:
2.	For ALL indications:
	Provider attests that member has none of the following contraindications to therapy: $\ \ \ \ \ \ \ \ \ \ \ \ \ $
	Breast cancer in a member assigned male at birth
	PregnancyProstate cancer
	If no , please specify contraindication and medical rationale for use:
	te: If member has had history with injectable/topical product within the past 120 days,
	nfirmed by claims history, and are switching formulations to nonpreferred injectable formulation, authorization criteria will apply
	authorization:
L.	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 $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$
	If no , please specify contraindication and medical rationale for use:
ne	ote: dose requested for reauthorization should not exceed established quantity limits unless ember 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

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Init	าดเ	Αı	itha	1717	atic	n.

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 does:
	\square Member is 16 years of age or older, has a total testosterone level \le 400 ng/dL while on topical testosterone therapy (Documentation is required) and is requesting to exceed established quantity limits \square Yes \square No
	Requested does:
	Member has utilized ≥ 14 days of topical testosterone therapy ☐ Yes ☐ No Name of medication:
	Does:
	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: $\ \ \ \ \ \ \ \ \ \ \ \ \ $
	Breast cancer in a member assigned male at birth
	Pregnancy
	Prostate cancer
	If no , please specify contraindication and medical rationale for use:
со	ote: If member has had history with injectable/topical product within the past 120 days, infirmed by claims history, and are switching formulations to nonpreferred injectable formulation, authorization criteria will apply

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** 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, 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 (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: \(\subseteq \text{Yes} \subseteq \text{No} \) Active or history of thrombosis or Pregnancy or breast-feeding thromboembolic disease · Severe hepatic disease Androgen-dependent tumor Severe renal disease Cardiac disease Undiagnosed genital bleeding Porphyria If **no**, please specify contraindication and medical rationale for use:

DA	NAZOL:
Re	authorization (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 $\ \ \ \ \ \ \ \ \ \ \ \ \ $
	If no , please specify contraindication and medical rationale for use:
LA	TENZO (TECTOCTERONE LINDECANIOATE).
	TENZO (TESTOSTERONE UNDECANOATE):
	itial Authorization:
1.	Member is 18 years of age or older and is requesting to use oral testosterone within the
	established quantity limits
	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)
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)
	If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
	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:
Re	authorization:
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

JA	TENZO (TESTOSTERONE UNDECANOATE):
	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:
No	te: dose requested for reauthorization should not exceed established quantity limits
	Requested dose:
ME	THITEST (METHYLTESTOSTEDONE)
	THITEST (METHYLTESTOSTERONE) Itial Authorization (approval up to 6 months):
	Please select one of the following:
	☐ Member has a diagnosis of cryptorchidism
	☐ Member has a diagnosis of delayed puberty
	\square Member has a diagnosis of hypogonadism (primary or hypogonadotropic) with a total testosterone \leq 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, 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:

ME	THITEST (METHYLTESTOSTERONE)
4.	Dose requested of methyltestosterone is within the established quantity limits:
	Requested dose:
Re	authorization (approval up to 6 months):
	Please select one of the following
	\square Member has a diagnosis of hypogonadism and a total testosterone level \le 1000 ng/dL within the past 6 months (Documentation is required)
2.	☐ 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. 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
No	testosterone agents:
	Requested dose:
	ANDO (TESTOSTERONE UNDECANOATE)
	tial Authorization:
1.	Member is 18 years of age or older and is requesting to use oral testosterone within the established quantity limits
	Requested dose:
2.	Member has a diagnosis of hypogonadism and a total testosterone level \leq 350 ng/dL within the past 3 months (Documentation is required) \square Yes \square 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:

TL	ANDO (TESTOSTERONE UNDECANOATE)
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:
Do	authorization:
	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
۷.	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)
	If no , please provide medical justification for use of requested agent over ALL preferred injectable
	testosterone agents:
No	te: dose requested for reauthorization should not exceed established quantity limits
	Requested dose:
	IDECATREX (TESTOSTERONE UNDECANOATE)
	itial Authorization:
1.	Member is 18 years of age or older and is requesting to use oral testosterone within the
	established quantity limits
	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

UN	IDECATREX (TESTOSTERONE UNDECANOATE)
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 cancer
	If no , please specify contraindication and medical rationale for use:
Da	authorization:
	Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required)
Τ.	
	☐ 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
٠.	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:
Nο	te: dose requested for regulthorization should not exceed established quantity limits
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No	te: dose requested for reauthorization should not exceed established quantity limits Requested dose:

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