SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Testosterone Replacement Therapy -TRT (Pharmacy)

Drug Requested: (Select applicable drug below)

PREFERRED	
❑ **testosterone gel 1%, 1.62%, 2%**	❑ **testosterone injection**
❑ **testosterone solution**	
NON-PREFERRED	
❑ **Androderm®** (testosterone patch)	❑ **Kyzatrex™** (testosterone undecanoate) **capsules**
❑ **Natesto®** (testosterone nasal gel)	❑ **Vogelxo® 1%** (testosterone gel)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

- **Testosterone replacement should be avoided in patients with breast or prostate cancer.**

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must meet **ONE** of the following:
  - ❑ Member is 19 years of age or older and has a diagnosis of Partial Androgen Insensitivity Syndrome with male gender identity/gender dysphoria

    Note: For FAMIS members, Gender Dysphoria Diagnosis is an **Excluded Benefit for members under 19** years of age.

    In accordance with a new federal rule (2026-16508 (91 FR 52406)), the Department of Medical Assistance Services (DMAS) will no longer cover gender-affirming procedures, including certain drugs/hormone therapies, to youth enrolled in Medicaid and the Children's Health Insurance Program (CHIP) beginning **October 13, 2026**. These restrictions also prohibit states' use of the federal Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) pathway to provide coverage of these services to children under 18.
  - ❑ Member has **ONE** of the following diagnoses of a disorder of sex development **(documentation must be submitted)**:
    - ❑ Q56.0-Q56.4 (sex differentiation disorders)
    - ❑ Q98.x (Klinefelter syndrome)
    - ❑ Q99.0 (46,XX/46,XY chimerism)
    - ❑ E30.0-E30.9 (puberty disorders)
    - ❑ E34.5 (Androgen insensitivity syndrome)
  - ❑ Member has hypogonadism confirmed by **BOTH** of the following:
    - ❑ **TWO (2) MORNING (6AM to 11AM)** testosterone levels **obtained on different dates** that are below 300 ng/dL or below the lower limit of normal for the reference range **(attach lab results with reference ranges from the laboratory for both)**
      - ❑ First testosterone level: _____
      - ❑ Repeat testosterone or free testosterone level: _____
    - ❑ Member has at least **one** specific symptom and at least **two** non-specific symptoms **[NOTE: If 'decreased spontaneous erections' is the ONLY symptom documented in chart notes, the request will be denied as testosterone replacement is EXCLUDED from coverage for sexual dysfunction]**:

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Specific symptoms (≥ 1 of the following)	**Non-Specific Symptoms** (≥ 2 of the following)
❑ Incomplete or delayed sexual development ❑ Reduced sexual desire (libido) and activity ❑ Decreased spontaneous erections* ❑ Breast discomfort, gynecomastia ❑ Loss of body (axillary, facial, and/or pubic) hair ❑ Small testes (<5 mL) or shrinking testes ❑ Low or zero sperm count ❑ Height loss, low trauma fracture, or low bone mineral density ❑ Hot flushes, sweats	❑ Decreased energy, motivation, initiative, and self- confidence ❑ Depressed mood ❑ Poor concentration and memory ❑ Sleep disturbance, increased sleepiness ❑ Mild anemia (Hgb 10-12) ❑ Reduced muscle bulk and strength due to Cachexia ❑ Increased body fat, BMI ❑ Diminished physical or work performance

❑ **For use of Non-Preferred Agents (Androderm®, Kyzatrex™, Natesto®, Vogelxo®):** Member has tried and failed testosterone gel 1%, 1.62%, 2%, testosterone solution or testosterone injection

Note: For the hypogonadism indication, testosterone drugs cannot be used in conjunction with other erectile dysfunction drugs.

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by the Pharmacy and Therapeutics Committee**: ~~6/16/2011; 7/16/2015; 10/19/2017;~~ **~~11/18/2022;~~ 9/25/2025**
REVISED/UPDATED/REFOMATTED: ~~9/8/2011, 6/21/2012; 7/1/2012; 7/30/2012; 10/17/2013; 12/27/2013; 3/19/2014; 4/16/2015;~~ **~~4/28/2015~~**~~; 5/22/2015; 10/12/2015; 12/29/2015; 4/17/16; 5/6/2016; 8/11/2016; 9/28/2016; 12/20/2016; 8/18/2017; 12/19/2017; 2/15/2019; 5/14/2019; 8/27/2019; 3/23/2022; 11/29/2022; 10/27/2023; 3/15/2024, 12/30/2025,~~ **10/12/2026**