

# AvMed

## 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 1-305-671-0200.** 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  |  |
|--|--|
| <input type="checkbox"/> testosterone gel 1%, 1.62%, 2%                | <input type="checkbox"/> testosterone injection                                    |
| <input type="checkbox"/> testosterone solution                         |  |
| NON-PREFERRED  |  |
| <input type="checkbox"/> Androderm <sup>®</sup> (testosterone patch)   | <input type="checkbox"/> Kyzatrex <sup>™</sup> (testosterone undecanoate) capsules |
| <input type="checkbox"/> Natesto <sup>®</sup> (testosterone nasal gel) | <input type="checkbox"/> Vogelxo <sup>®</sup> 1% (testosterone gel)                |

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

Member Name: \_\_\_\_\_

Member AvMed #: \_\_\_\_\_ 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 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.

(Continued on next page)

**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 has Partial Androgen Insensitivity Syndrome with male gender identity/gender dysphoria or delayed male puberty
  - Member has hypogonadism confirmed by low testosterone levels
- For members with a diagnosis of hypogonadism, **TWO (2) MORNING (6AM to 11AM)** testosterone levels **obtained on different dates (attach lab results for both ranges)**
  - First level: \_\_\_\_\_
  - AND**
  - Repeat testosterone or free testosterone level: \_\_\_\_\_
  - AND**
  - Member has the following symptoms:

| <b><u>Specific symptoms</u></b> (≥ 1 of the following)  | <b><u>AND</u></b> | <b><u>Non-Specific Symptoms</u></b> (≥ 2 of the following)  |
|---|-------------------|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Incomplete or delayed sexual development</li> <li><input type="checkbox"/> Reduced sexual desire (libido) and activity</li> <li><input type="checkbox"/> Decreased spontaneous erections*</li> <li><input type="checkbox"/> Breast discomfort, gynecomastia</li> <li><input type="checkbox"/> Loss of body (axillary, facial, and/or pubic) hair</li> <li><input type="checkbox"/> Small testes (&lt;5 mL) or shrinking testes</li> <li><input type="checkbox"/> Low or zero sperm count</li> <li><input type="checkbox"/> Height loss, low trauma fracture, or low bone mineral density</li> <li><input type="checkbox"/> Hot flushes, sweats</li> </ul> | <b><u>AND</u></b> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Decreased energy, motivation, initiative, and self- confidence</li> <li><input type="checkbox"/> Depressed mood</li> <li><input type="checkbox"/> Poor concentration and memory</li> <li><input type="checkbox"/> Sleep disturbance, increased sleepiness</li> <li><input type="checkbox"/> Mild anemia (Hgb 10-12)</li> <li><input type="checkbox"/> Reduced muscle bulk and strength due to Cachexia</li> <li><input type="checkbox"/> Increased body fat, BMI</li> <li><input type="checkbox"/> Diminished physical or work performance</li> </ul> |

\*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.

In addition, for use of Non-Preferred Agents (Androderm<sup>®</sup>, Kyzatrex<sup>™</sup>, Natesto<sup>®</sup>, Vogelxo<sup>®</sup>):

- 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.\***