

SENTARA COMMUNITY PLAN (MEDICAID)

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	
<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 [®] (testosterone patch)	<input type="checkbox"/> Kyzatrex [™] (testosterone undecanoate) capsules
<input type="checkbox"/> Natesto [®] (testosterone nasal gel)	<input type="checkbox"/> 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 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:

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

*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[®], 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/REFORMATTED: 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.