SENTARA HEALTH PLANS

MEDICAL 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 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Testosterone Replacement Therapy (TRT) Injectables
(MUST be purchased by Physician's Office)

Drug Requested: (Check box below that applies)

PREFERRED	
❑ **testosterone cypionate injection (J1071)**	❑ **testosterone enanthate injection (J3121)**

NON-PREFERRED		
❑ **Aveed**® (testosterone undecanoate) IM injection **(J3145)**	❑ **Azmiro** (testosterone cypionate) IM injection **(J1072)**	❑ **Testopel**® (testosterone pellets) **(J1073)**

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:** _____

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❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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

Maximum Dosage:

- Aveed – 3 mL (750 mg) injected intramuscularly, followed by 3 mL (750 mg) injected after 4 weeks, then 3 mL (750 mg) injected every 10 weeks
- Azmiro – 50 to 400 mg administered every two to four weeks as an intramuscular injection
- Testopel – 75 mg implantable pellet; 6 pellets per 90-day supply (6 billable units every 90 days)

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.

Length of Authorization: 12 months

❑ 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: _____

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- ❑ 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]**:

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 hair (axillary, facial, and/or pubic) ❑ 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 disturbances, increased sleepiness ❑ Mild anemia (Hgb 10-11 gm/dL) ❑ Reduced muscle bulk and strength due to cachexia ❑ Increased body fat, BMI ❑ Diminished physical or work performance

AND

- ❑ Member has had an inadequate response, contraindication or intolerance to at least a three-month trial with a topical agent e.g., testosterone gel, testosterone patch, testosterone topical solution, testosterone nasal gel **(verified by pharmacy paid claims)**

  (Please document date/name of drug _____

AND

- ❑ Member has had an inadequate response, contraindication or intolerance to at least a three-month trial of a preferred intramuscular testosterone medication e.g., testosterone cypionate or testosterone enanthate **(verified by pharmacy or medical paid claims)**

  (Please document date/name of drug) _____

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Medication being provided by (check box below that applies)**:**

- ❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call Sentara Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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:** ~~3/19/2014;~~ **1/23/2025**
REVISED/UPDATED/REFORMATTED: ~~10/31/2014; 12/23/2014; 12/26/2014; 3/17/2015; 4/8/2015; 5/23/2015; 7/29/15; 10/12/2015; 12/28/2015; 1/29/2016; 2/12/2016; 3/31/2016; 4/17/2016; 5/6/2016; 12/11/2016; 7/24/2017; 2/15/2019; 3/23/2019; 6/20/2019; 7/8/2019; 9/25/2019; 7/7/2021; 12/9/2021; 12/23/2021; 2/19/2025; 1/02/2026; 6/12/2026;~~ **10/12/2026**