maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Testosterone Agents

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?

[] Initial (If checked, go to 6)

[] Continuation (If checked, go to 2)

2 What is the indication/diagnosis?

[] Hypogonadism in a male patient (If checked, go to 3)

[] Acquired immunodeficiency syndrome (AIDS)-associated wasting (If checked,

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	go to 7)		
	[] Delayed puberty (If checked, go to 5)		
	[] Palliative treatment of inoperable breast cancer in women (If checked, go to 28)		
	[] Transgender (If checked, go to 30)		
	[] Other (If checked, no further questions)		
3	Is the patient's testosterone level within normal range? [If yes, skip to question 32.]	Yes	No
4	Has the patient shown an improvement in symptoms? [If yes, skip to question 32.] [If no, no further questions.]	Yes	No
5	Does the patient have an X-ray of the hand and wrist done every 6 months to determine bone age and to assess the effect of treatment on the epiphyseal centers? [If yes, skip to question 32.] [If no, no further questions.]	Yes	No
6	What is the indication/diagnosis?		
	[] Hypogonadism in a male patient (If checked, go to 7)		
	[] Acquired immunodeficiency syndrome (AIDS)-associated wasting (If checked, go to 7)		
	[] Delayed puberty (If checked, go to 26)		
	[] Palliative treatment of inoperable breast cancer (If checked, go to 28)		
	[] Transgender (If checked, go to 30)		
	[] Other (If checked, no further questions)		
7	Has the diagnosis been confirmed by two separate morning (A.M.) serum testosterone measurements with results below normal range? [If no, no further questions.]	Yes	No
8	Does the patient have AT LEAST one low total testosterone level (below the normal range for the laboratory) WITH elevated follicle-stimulating hormone (FSH) and/or luteinizing hormone (LH)? [If yes, skip to question 10.]	Yes	No
9	Does the patient have AT LEAST two total testosterone levels, both of which are	Yes	No

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	LESS THAN normal based upon the laboratory reference range WITH AT LEAST one low free testosterone level (below the normal range for the laboratory)? [If no, no further questions.]		
10	Does the patient have breast discomfort or gynecomastia? [If yes, skip to question 17.]	Yes	No
11	Does the patient have any loss of body (axillary and pubic) hair? [Note: Reduced shaving if needed.] [If yes, skip to question 17.]	Yes	No
12	Does the patient have very small (especially LESS THAN 5 mL) or shrinking testes? [If yes, skip to question 17.]	Yes	No
13	Does the patient have the inability to father children or have low/zero sperm count? [If yes, skip to question 17.]	Yes	No
14	Does the patient have height loss, low trauma fracture, or low bone mineral density? [If yes, skip to question 17.]	Yes	No
15	Does the patient have hot flushes and/or sweats? [If yes, skip to question 17.]	Yes	No
16	Does the patient have any less specific signs and symptoms including decreased energy, depressed mood/dysthymia, irritability, sleep disturbance, poor concentration/memory, diminished physical or work performance? [If no, no further questions.]	Yes	No
17	What is the indication/diagnosis? [] Hypogonadism in a male patient (If checked, go to 18) [] Acquired immunodeficiency syndrome (AIDS)-associated wasting (If checked, go to 25)		
18	Does the patient have metastatic prostate cancer? [If yes, no further questions.]	Yes	No
19	Does the patient have breast cancer? [If yes, no further questions.]	Yes	No
20	Does the patient have unelevated prostate nodules or induration? [If yes, no further questions.]	Yes	No
21	Does the patient have a prostate-specific antigen (PSA) GREATER THAN 4	Yes	No

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	ng/ml? [NOTE: GREATER THAN 3 ng/ml in individuals is at high risk for prostate cancer, such as African-Americans or men with first-degree relatives who have prostate cancer.] [If yes, no further questions.]		
22	Does the patient have a hematocrit GREATER THAN 50%? [If yes, no further questions.]	Yes	No
23	Does the patient have uncontrolled or poorly controlled congestive heart failure? [If yes, no further questions.]	Yes	No
24	Does the patient have severe lower urinary tract symptoms associated with benign prostatic hypertrophy as indicated by American Urological Association/International Prostate Symptom Score (AUA/IPSS) GREATER THAN 19? [If yes, no further questions.] [If no, skip to question 32.]	Yes	No
25	Is there documentation that the patient has adequate nutritional support/caloric intake? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 32.] [If no, no further questions.]	Yes	No
26	Is the patient an adolescent male? [If no, no further questions.]	Yes	No
27	Was a baseline x-ray of the hand and wrist completed to determine bone age? [If yes, skip to question 32.] [If no, no further questions.]	Yes	No
28	Is the patient a female? [If no, no further questions.]	Yes	No
29	Is the requested medication being prescribed by an oncologist? [If yes, skip to question 32.] [If no, no further questions.]	Yes	No
30	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
31	Did the patient undergo a gender change from female to male or is currently in the process of transitioning? [NOTE: A female is defined as an individual with the biological traits of a female, regardless of the individual's gender identity or gender expression.] [If no, no further questions.]	Yes	No
32	Is the request for a non-formulary product? [If no, no further questions.]	Yes	No

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33	Has the patient tried at least TWO formulary agents IN THE SAME DRUG CLASS (if two formulary agents are available) as the requested medication? If yes, please document all medications tried and reason for treatment failure _____. [If yes, no further questions.]	Yes	No
34	Does the patient have a contraindication, such as drug allergy or serious drug interaction, to the preferred formulary alternatives?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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