Iowa Department of Human Services

Request for Prior Authorization
TESTOSTERONE PRODUCTS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for testosterone products. Payment will be considered with documentation of a specific testicular or hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism. Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis. Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for erectile dysfunction, infertility, and age-related hypogonadism will not be considered. Payment will be considered under the following conditions:

1) **Patient is male and 18 years of age or older (or 12 years of age and older for testosterone cypionate); and**
2) **Patient has two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (attach results); and**
3) **Patient has primary hypogonadism or hypogonadotropic hypogonadism (further defined below)**
    - **Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following: cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, toxic damage from alcohol or heavy metals**
    - **Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency, pituitary-hypothalamic injury from tumors, trauma, or radiation**
4) **Patient does not have:**
    - **Breast or prostate cancer**
    - **Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL**
    - **Hematocrit > 50%**
    - **Untreated severe obstructive sleep apnea**
    - **Severe lower urinary tract symptoms**
    - **Uncontrolled or poorly controlled heart failure**

If criteria for coverage are met, initial authorizations will be given for 3 months. Requests for continuation of therapy will require the following:

- **An updated testosterone level (attach result); and**
- **Documentation the patient has not experienced a hematocrit > 54% or an increase in PSA > 1.4ng/mL in the past 12 months.**

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Preferred

- ☐ Androderm
- ☐ Methitest
- ☐ Testosterone Cypionate
- ☐ Testosterone Enanthate
- ☐ Testosterone Gel 1% Packets

Non-Preferred

- ☐ Androgel
- ☐ Android
- ☐ Aveed
- ☐ Axiron
- ☐ Depo-Testosterone
- ☐ Fortesta
- ☐ Methyltestosterone
- ☐ Natesto
- ☐ Striant
- ☐ Testim
- ☐ Testosterone Gel 1.62%
- ☐ Testosterone Gel Pump
- ☐ Testosterone Topical Solution
- ☐ Testred
- ☐ Xyosted
- ☐ Vogelxo

Strength_____ **Dosage Instructions**_____ **Quantity**_____ **Days Supply**_____

Complete for diagnosis of hypogonadism:

☐ Primary Hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:

☐ Cryptorchidism ☐ Bilateral torsion ☐ Orchitis ☐ Vanishing testes syndrome ☐ Orchiectomy

☐ Klinefelter's syndrome ☐ Chemotherapy ☐ Toxic damage from alcohol or heavy metals

☐ Other: _____

☐ Hypogonadotropic Hypogonadism:

☐ Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency

☐ Pituitary-hypothalamic injury from tumors, trauma, or radiation

Please indicate setting in which medication is to be administered: _____

List & attach results of two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used:

Level 1:_____ Date:_____ Level 2:_____ Date:_____

Does patient have any of the following:

Breast or prostate cancer:	☐ Yes	☐ No
Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL:	☐ Yes	☐ No
Hematocrit > 50%:	☐ Yes	☐ No
Untreated severe obstructive sleep apnea:	☐ Yes	☐ No
Severe lower urinary tract symptoms:	☐ Yes	☐ No
Uncontrolled or poorly controlled heart failure:	☐ Yes	☐ No

Renewal Requests:

List & attach updated testosterone level: Level:_____ Date:_____

Has patient experienced the following in the past 12 months:

Hematocrit > 54%:	☐ Yes	☐ No	Most recent lab date:_____
Increase in PSA > 1.4ng/mL:	☐ Yes	☐ No	Most recent lab date:_____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*