TRICARE Prior Authorization Request Form for
testosterone cypionate and testosterone enanthate IM injections

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization for initial therapy expires in 1 year. Prior authorization for continuation of therapy does not expire.
Prior authorization is not required for patients less than 1 year of age.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Will the requested medication be used concomitantly with other testosterone products?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes (subject to verification) Proceed to question **3**	☐ No Proceed to question **5**
3. Has the patient had a positive response to therapy?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Do the risks of continued therapy outweigh the benefits?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
5. What is the diagnosis or indication?	☐ Hypogonadism - Proceed to question **6** ☐ Female-to-male gender reassignment (endocrinologic masculinization) - Proceed to question **13** ☐ Breast cancer - Proceed to question **21** ☐ Other - **STOP Coverage not approved**	

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6. Was the patient male at birth?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient 18 years of age or older?	☐ Yes Proceed to question **9**	☐ No Proceed to question **8**
8. Is the prescription written by or in consultation with a pediatric endocrinologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Does the patient have a diagnosis of hypogonadism as evidenced by 2 or more morning total testosterone levels below 300 ng/dL?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the provider investigated the etiology of the low testosterone levels and acknowledges that testosterone therapy is clinically appropriate and needed?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have prostate cancer?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Is the patient experiencing symptoms usually associated with hypogonadism?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Does the patient have a diagnosis of gender dysphoria made by a TRICARE authorized mental health provider according to most current edition of the DSM?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Is the patient an adult?	☐ Yes Proceed to question **17**	☐ No Proceed to question **15**
15. Is the patient greater than or equal to 16 years of age?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Has the patient experienced puberty to at least Tanner stage 2?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**

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17. Does the patient have signs of breast cancer?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **18**
18. Is the patient a biological female of childbearing potential?	☐ Yes Proceed to question **19**	☐ No Proceed to question **20**
19. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **20**
20. Does the patient have psychiatric comorbidity that would confound a diagnosis of gender dysphoria or interfere with treatment (for example, unresolved body dysmorphic disorder; schizophrenia or other psychotic disorders that have not been stabilized with treatment)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
21. Is the patient female?	☐ Yes Proceed to question **22**	☐ No **STOP** **Coverage not approved**
22. Is the prescription written by or in consultation with an oncologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[5 April 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: