Prior Authorization Request Form for

testosterone undecanoate capsules **(Jatenzo, Kyzatrex, Tlando)**

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.

Step 1 **Medication requested:**

Step 2 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 3 **Please complete the clinical assessment:**

1. Is the requested medication being used for female-to-male gender reassignment (endocrinologic masculinization)?	☐ Yes **SKIP to question 7**	☐ No **Proceed to question 2**
2. Is the patient a male who is greater than 17 years of age?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. 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 4**	☐ No **STOP** **Coverage not approved**
4. 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 5**	☐ No **STOP** **Coverage not approved**
5. Is the patient experiencing symptoms usually associated with hypogonadism?	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried Fortesta (testosterone 2% gel) or testosterone 1% gel (Androgel 1% generic) for a minimum of 90 days AND failed to achieve total serum testosterone levels above 400 ng/dL (labs drawn 2 hours after Fortesta or testosterone 1% gel (Androgel 1% generic) application) AND without improvement in symptoms?	☐ Yes **SKIP to question 15**	☐ No **SKIP to question 13**

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7. 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 8**	☐ No **STOP** **Coverage not approved**
8. Is the patient 16 years of age or older?	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**
9. Is the patient a biological female of childbearing potential?	☐ Yes **Proceed to question 10**	☐ No **SKIP to question 11**
10. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 11**
11. Has the patient experienced puberty to at least Tanner stage 2?	☐ Yes **Proceed to question 12**	☐ No **STOP** **Coverage not approved**
12. 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 **Proceed to question 13**
13. Does the patient have a contraindication to Fortesta or testosterone 1% gel (Androgel 1% generic) that does not apply to the requested medication?	☐ Yes **Proceed to question 15**	☐ No **Proceed to question 14**
14. Does the patient require a testosterone replacement therapy that has a low risk of skin-to-skin transfer between family members?	☐ Yes **Proceed to question 15**	☐ No **STOP** **Coverage not approved**
15. Does the patient have carcinoma of the breast or suspected prostate cancer?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 16**
16. Does the patient have uncontrolled hypertension or are they at risk for cardiovascular events (for example, myocardial infarction or stroke) prior to starting therapy with the requested medication?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 17**
17. Will the requested medication be used concomitantly with another testosterone replacement therapy product?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 4 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[23 Nov 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: