TRICARE Prior Authorization Request Form for
Testosterone cypionate IM, testosterone enanthate IM, testosterone enanthate (Xyosted)

JOHNS HOPKINS
HEALTH PLANS
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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 is not required for patients younger than 1 year of age.
Prior authorization for initial therapy expires in 1 year. Prior authorization for continuation of therapy for adults does not expire. Prior authorization for continuation of therapy for children expires in 1 year.

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 to enhance athletic performance?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Will the requested medication be used concomitantly with other testosterone products?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. 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 **4**	☐ No Proceed to question **6**
4. Has the patient had a positive response to therapy?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Do the benefits of continued therapy outweigh the risks?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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6. What is the diagnosis or indication?	☐ Hypogonadism - Proceed to question **7** ☐ Female-to-male gender-affirming hormone therapy in a natal female patient (assigned female at birth) - Proceed to question **15** ☐ Breast cancer - Proceed to question **23** ☐ Other - Proceed to question **28**	
7. Is the patient a male who is 18 years of age or older?	☐ Yes Proceed to question **10**	☐ No Proceed to question **8**
8. What is the requested medication?	☐ Testosterone cypionate IM- Proceed to question **9** ☐ Testosterone enanthate IM- Proceed to question **9** ☐ Xyosted – **STOP Coverage not approved**	
9. Is the prescription written by or in consultation with a pediatric endocrinologist or pediatric urologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
10. Does the patient have a confirmed diagnosis of hypogonadism as evidenced by 2 or more morning total serum testosterone levels below 300 ng/dL taken on at least two separate occasions?	☐ Yes Proceed to question **12**	☐ No Proceed to question **11**
11. Is the requested medication prescribed by an endocrinologist or urologist who has made the diagnosis of hypogonadism based on unequivocally and consistently low serum total testosterone or free testosterone levels?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient experiencing signs and symptoms associated with hypogonadism?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Has the provider investigated the etiology of the low testosterone levels and has assessed the risks versus benefits of initiating testosterone therapy in this patient?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Does the provider acknowledge that testosterone therapy is clinically appropriate and needed?	☐ Yes Proceed to question **25**	☐ No **STOP** **Coverage not approved**
15. Is the patient greater than or equal to 14 years of age?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**

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16. Does the patient have a diagnosis of gender dysphoria made by a TRICARE authorized mental health provider according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Is the prescription written by an endocrinologist or a physician who specializes in the treatment of transgender patients?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Is the patient an adult, or an adolescent with sufficient mental capacity to give informed consent for this partially irreversible treatment?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. Has the patient experienced puberty to at least Tanner stage 2?	☐ Yes Proceed to question **20**	☐ No **STOP** **Coverage not approved**
20. Is the patient of childbearing potential?	☐ Yes Proceed to question **21**	☐ No Proceed to question **22**
21. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **22**
22. Does the patient have a 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 **25**
23. Is the patient female?	☐ Yes Proceed to question **24**	☐ No **STOP** **Coverage not approved**
24. Is the prescription written by or in consultation with an oncologist?	☐ Yes Proceed to question **25**	☐ No **STOP** **Coverage not approved**
25. What is the requested medication?	☐ Testosterone cypionate IM - **Sign and date below** ☐ Testosterone enanthate IM **- Sign and date below** ☐ Xyosted - Proceed to question **26**	

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26. Has the patient tried and failed a 3 month trial of one drug from each of the following two categories: (1) Testosterone cypionate IM injection or Testosterone enanthate IM injection; (2) Testosterone 2% gel (Fortesta) or generic testosterone 1% gel (Androgel)?	☐ Yes **Sign and date below**	☐ No Proceed to question **27**
27. Has the patient experienced a clinically significant adverse reaction, or had a contraindication or relative contraindication to one drug from each of the following two categories: (1) Testosterone cypionate IM injection or Testosterone enanthate IM injection; (2) Testosterone 2% gel (Fortesta) or generic testosterone 1% gel (Androgel)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
28. If the indication is not listed above, please write in requested indication and rationale for use.	_____ Proceed to question **29**	
29. What is the requested medication?	☐ Testosterone cypionate IM - **Sign and date below** ☐ Testosterone enanthate IM **- Sign and date below** ☐ Xyosted - Proceed to question **30**	
30. Has the patient tried and failed a 3 month trial of one drug from each of the following two categories: (1) Testosterone cypionate IM injection or Testosterone enanthate IM injection; (2) Testosterone 2% gel (Fortesta) or generic testosterone 1% gel (Androgel)?	☐ Yes **Sign and date below**	☐ No Proceed to question **31**
31. Has the patient experienced a clinically significant adverse reaction, or had a contraindication or relative contraindication to one drug from each of the following two categories: (1) Testosterone cypionate IM injection or Testosterone enanthate IM injection; (2) Testosterone 2% gel (Fortesta) or generic testosterone 1% gel (Androgel)?	☐ 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

[12 July 2023]

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