Prior Authorization Request Form for
testosterone enanthate SQ injection **(Xyosted)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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.

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. What is the indication or diagnosis?	☐ Hypogonadism (hypogonadal conditions associated with structural or genetic etiologies) - Proceed to question **2** ☐ Female to male gender reassignment (endocrinologic masculinization) – Proceed to question **6** ☐ Other – **STOP** Coverage not approved	
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the patient biologically a male?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Is there documentation to confirm that the patient has been experiencing signs and symptoms usually associated with hypogonadism?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Was the diagnosis of hypogonadism confirmed and evidenced by morning total serum testosterone levels below 300 ng/dL taken on AT LEAST TWO separate occasions?	☐ Yes Proceed to question **13**	☐ No **STOP** Coverage not approved
6. Does the patient a have a diagnosis of gender dysphoria made by a TRICARE-authorized mental health provider according to the most current edition if DSM?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved

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7. Is the patient 16 years of age or older?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Is the patient a biologic female of childbearing potential?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **10**
10. Has the patient experienced puberty to at least Tanner stage 2?	☐ Yes Proceed to question **11**	☐ No **STOP** Coverage not approved
11. 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 has not been stabilized on treatment)?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **12**
12. Does the patient have a documented minimum of three months of real-life experience (RLE) and/or three month of continuous psychotherapy addressing gender transition as an intervention for gender dysphoria?	☐ Yes Proceed to question **13**	☐ No **STOP** Coverage not approved
13. Does the patient have carcinoma of the breast or suspected carcinoma of the prostate?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **14**
14. Has the provider considered the patient's baseline cardiovascular risk and ensured blood pressure are adequately controlled before initiating therapy with the requested medication and periodically during the course of treatment (based on the product's boxed warning of increased risk of major adverse cardiovascular events and hypertension)?	☐ Yes Proceed to question **15**	☐ No **STOP** Coverage not approved
15. Has the patient tried Fortesta (testosterone 2% gel) for a minimum of 90 days?	☐ Yes Proceed to question **17**	☐ No Proceed to question **16**
16. Does the patient have a contraindication to or has experienced a clinically significant adverse reaction to Fortesta that is not expected to occur with the Xyosted autoinjector?	☐ Yes Proceed to question **18**	☐ No **STOP** Coverage not approved
17. Did the patient fail to achieve total serum testosterone levels above 400 ng/dL (labs drawn two hours after Fortesta application) and experienced no improvement in symptoms associated with low testosterone?	☐ Yes Proceed to question **18**	☐ No **STOP** Coverage not approved

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18. Has the patient tried an injectable testosterone formulation for a minimum of 90 days?	☐ Yes Proceed to question **19**	☐ No Proceed to question **20**
19. Did the patient fail to achieve total serum testosterone levels above 400 ng/dL (labs drawn two hours after using an injectable testosterone formulation) and experienced no improvement in symptoms associated with low testosterone?	☐ Yes Proceed to question **21**	☐ No **STOP** Coverage not approved
20. Does the patient have a contraindication to or has experienced a clinically significant adverse reaction to other injectable testosterones that is not expected to occur with the Xyosted autoinjector?	☐ Yes Proceed to question **21**	☐ No **STOP** Coverage not approved
21. Will Xyosted be used in combination with another testosterone product?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

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

_____ _____

Prescriber Signature Date

[4 June 2019]

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