

Androderm, AndroGel, Axiron, Natesto, Striant, Testim, Testosterone 1% & 1.62% gel, Vogelxo, Jatenzo



7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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

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)?	<input type="checkbox"/> Yes SKIP to question 6	<input type="checkbox"/> No Proceed to question 2
2. Is the patient a male who is greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> 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 ?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is the patient experiencing symptoms usually associated with hypogonadism?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Has the patient tried Fortesta (testosterone 2% gel) for a minimum of 90 days AND failed to achieve total serum testosterone levels above 400 ng/dL (labs drawn 2 hours after Fortesta application) AND without improvement in symptoms?	<input type="checkbox"/> Yes Sign and date on page 2	<input type="checkbox"/> No SKIP to question 13
6. 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?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. Is the patient 16 years of age or older?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
8. Is the patient a biological female of childbearing potential?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No SKIP to question 10

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 Vogelxo, Jatenzo**

9. Is the patient pregnant or breastfeeding	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 10
10. Has the patient experienced puberty to at least Tanner stage 2?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
11. 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)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 12
12. Does the patient have a documented minimum of three months of real-life experience (RLE) and/or three months of continuous psychotherapy addressing gender transition as an intervention for gender dysphoria?	<input type="checkbox"/> Yes Proceed to question 17	<input type="checkbox"/> No Coverage not approved
13. Does the patient have a contraindication or relative contraindication to Fortesta that does not apply to the requested agent?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 14
14. Has the patient experienced a clinically significant skin reaction to Fortesta that is not expected to occur with the requested agent?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 15
15. Is the request for Androderm, Natesto, Striant or Jatenzo?	<input type="checkbox"/> Yes Proceed to question 16	<input type="checkbox"/> No STOP Coverage not approved
16. Does the patient require a testosterone replacement therapy that has a low risk of skin-to-skin transfer between family members?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
17. Does the patient have a contraindication or relative contraindication to Fortesta that does not apply to the requested agent?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 18
18. Has the patient experienced a clinically significant skin reaction to Fortesta that is not expected to occur with the requested agent?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 19
19. Is the request for Androderm, Natesto, Striant, or Jatenzo?	<input type="checkbox"/> Yes Proceed to question 20	<input type="checkbox"/> No STOP Coverage not approved
20. Does the patient require a testosterone replacement therapy that has a low risk of skin-to-skin transfer between family members?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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

_____ Prescriber Signature

_____ Date

[29 January 2020]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: