Prior Authorization Request Form for

Fortesta (testosterone 2% topical gel)

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

USFHP Pharmacy Prior Authorization Form

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

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 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 5**	☐ 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. Is the patient experiencing symptoms usually associated with hypogonadism?	☐ Yes **Sign and date on page 2**	☐ No **STOP Coverage not approved**
5. 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 6**	☐ No **STOP Coverage not approved**
6. Is the patient 16 years of age or older?	☐ Yes **Proceed to question 7**	☐ No **STOP Coverage not approved**
7. Is the patient a biological female of childbearing potential?	☐ Yes **Proceed to question 8**	☐ No **SKIP to question 9**
8. Is the patient pregnant or breastfeeding	☐ Yes **STOP Coverage not approved**	☐ No **Proceed to question 9**
9. Has the patient experienced puberty to at least Tanner stage 2?	☐ Yes **Proceed to question 10**	☐ No **STOP Coverage not approved**

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10. 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 11**
11. 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?	☐ Yes **Sign and date below**	☐ 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

[10 May 2017]

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