OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Androgens Prior Authorization Request Form (Page 1 of 3)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Delayed puberty
❑ Gender dysphoria
❑ Hypogonadism (e.g., testicular hypofunction, male hypogonadism, ICD-10 code E29.1)
❑ Inoperable breast cancer, palliative treatment
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Continuation of therapy:

Is this a continuation of testosterone therapy? ❑ **Yes** ❑ **No**

Which gender was the patient at birth? (Select from one of the options below)

❑ Female ❑ Male

HYPOGONADISM (e.g., testicular hypofunction, male hypogonadism, ICD-10 code E29.1):

Does the patient have a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? ❑ **Yes** ❑ **No**

Does the patient have a history of one of the following: Bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)? ❑ **Yes** ❑ **No**

Laboratory information:

Total testosterone level:

Does the patient have two pre-treatment serum total testosterone levels less than 300 ng/dL (< 10.4 nmol/L) or less than the reference range for the lab, taken at separate times? ❑ **Yes** ❑ **No**

Please document **all** pre-treatment level(s) below and date taken:

Pre-treatment **serum total** Testosterone level 1: _____ Reference range: _____ Units of measure: _____ Date taken: _____
Pre-treatment **serum total** Testosterone level 2: _____ Reference range: _____ Units of measure: _____ Date taken: _____

Calculated free or bioavailable testosterone level:

Does the patient have one pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (< 0.17 nmol/L) or less than the reference range for the lab? ❑ **Yes** ❑ **No**

Please document the level(s) below and date taken:

Pre-treatment **calculated free or bioavailable** Testosterone level: _____ Reference range: _____
Units of measure: _____ Date taken: _____

Select if the patient has one of the following:

❑ Decreased bone density
❑ Decreased libido
❑ Osteopenia
❑ Osteoporosis
❑ Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)
❑ Significant reduction in weight (less than 90% ideal body weight) (e.g., AIDS wasting syndrome)

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GENDER DYSPHORIA:

Does the patient's diagnosis include gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)? ❑ **Yes** ❑ **No**

Is the patient using hormones to change physical characteristics? ❑ **Yes** ❑ **No**

Is the patient a female-to-male transsexual? ❑ **Yes** ❑ **No**

MEDICATION HISTORY:

Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Androderm (testosterone patch)
- ❑ Androgel 1% (testosterone gel)
- ❑ Androgel 1.62% gel (testosterone gel)
- ❑ Androgel 1.62% pump (testosterone pump)
- ❑ Fortesta (testosterone gel)
- ❑ Testim (testosterone gel)

Concurrent medications:

Is the patient taking one of the following growth hormones (Genotropin, Humatrope, Norditropin FlexPro, Norditropin NordiFlex, Nutropin, Nutropin AQ, Omnitrope, Saizen, Tev-Tropin)? ❑ **Yes** ❑ **No**

If yes, is the patient diagnosed with panhypopituitarism? ❑ **Yes** ❑ **No**

Is the patient taking an aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])? ❑ **Yes** ❑ **No**

REAUTHORIZATION:

If this is a reauthorization request, answer the following:

Is the patient's follow-up **total serum** testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), within or below the normal male limits of the reporting lab? ❑ **Yes** ❑ **No**

Is the patient's follow-up **total serum** testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), outside of the upper male limits of normal for the reporting lab and the dose has been adjusted? ❑ **Yes** ❑ **No**

Document the value and date taken:

Total serum Testosterone level: _____ Reference range: _____ Units of measure: _____ Date taken: _____

Is the patient's follow-up **calculated free or bioavailable** testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), within or below the normal male limits of the reporting lab? ❑ **Yes** ❑ **No**

Is the patient's follow-up **calculated free or bioavailable** testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), outside of the upper male limits of normal for the reporting lab and the dose has been adjusted? ❑ **Yes** ❑ **No**

Document the value and date taken:

Calculated free or bioavailable Testosterone level: _____ Reference range: _____
Units of measure: _____ Date taken: _____

Does the patient have a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? ❑ **Yes** ❑ **No**

Is the patient taking one of the following growth hormones (Genotropin, Humatrope, Norditropin FlexPro, Norditropin NordiFlex, Nutropin, Nutropin AQ, Omnitrope, Saizen, Tev-Tropin)? ❑ **Yes** ❑ **No**

If yes, is the patient diagnosed with panhypopituitarism? ❑ **Yes** ❑ **No**

Is the patient taking an aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.