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 2)

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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)

Continuation of therapy:
Is this request for a continuation of prior therapy? ❑ **Yes** ❑ **No**
If yes, is it within the past 120 days? ❑ **Yes** ❑ **No**

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

Medication History:

For nasal, oral, & topical testosterone requests, select the medications the patient has a failure, contraindication, or intolerance to:

❑ Androderm	❑ Testim	❑ Testosterone gel (generic Vogelxo)
❑ Androgel 1%	❑ Testosterone gel (10mg/actuation)	❑ Testosterone gel pump (generic Androgel 1% pump)
❑ Androgel 1.62%	❑ Testosterone gel (generic Androgel 1%)	❑ Testosterone gel pump (generic Androgel 1.62% pump)
❑ Androgel Pump 1%	❑ Testosterone gel (generic Androgel 1.62%)	❑ Testosterone gel pump (generic Vogelxo pump)
❑ Androgel Pump 1.62%	❑ Testosterone gel (generic Testim)	❑ Testosterone solution
❑ Striant		

For injectable testosterone requests, select the medications the patient has a failure, contraindication, or intolerance to:

❑ Aveed	❑ Testosterone cypionate	❑ Testosterone enanthate
❑ Depo-testosterone		

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

Laboratory information [Hypogonadism (e.g., testicular hypofunction, male hypogonadism, ICD-10 code E29.1)]:

Total testosterone level:
Does the patient have TWO pre-treatment serum total testosterone levels less than the reference range for the lab? ❑ **Yes** ❑ **No**
Does the patient have TWO pre-treatment serum total testosterone levels less than 300 ng/dL (<10.4 nmol/L)? ❑ **Yes** ❑ **No**

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**

Androgens Prior Authorization Request Form (Page 2 of 2)

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Clinical information [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**

Gender dysphoria or Gender identity disorder:

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

Reauthorization [Hypogonadism (e.g., testicular hypofunction, male hypogonadism, ICD-10 code E29.1)]:

If this is a reauthorization request, also answer the following questions:

Is the patient's follow-up **total serum** testosterone level within or below the normal limits of the reporting lab? ❑ **Yes** ❑ **No**

Is the patient's follow-up **total serum** testosterone level outside of the upper limits of normal for the reporting lab and the dose has been adjusted? ❑ **Yes** ❑ **No**

Is the patient's follow-up **calculated free or bioavailable** testosterone level within or below the normal limits of the reporting lab? ❑ **Yes** ❑ **No**

Is the patient's follow-up **calculated free or bioavailable** testosterone level outside of the upper limits of normal for the reporting lab and the dose has been adjusted? ❑ **Yes** ❑ **No**

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**

Quantity limit requests:

What is the quantity requested per MONTH? _____

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
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.