OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. Incomplete form will delay the authorization process.***

❑ **Will Testosterone Replacement therapy be *purchased by the Physician's office*? *(NOT AVAILABLE AT SPECIALTY PHARMACY - PropriumRx and/or BriovaRx)*** ❑ **Yes** ❑ **No**
If YES, fax form to Optima Medical Services **at 1-844-348-3720**

❑ **Will Testosterone Replacement therapy be *purchased by the member*? *(NOT AVAILABLE AT SPECIALTY PHARMACY – PropriumRx and/or BriovaRx)*** ❑ **Yes** ❑ **No**
If YES, fax form to*: *Optima Pharmacy Department **at 1-800-319-5003**

Check Drug Requested Below. If NOT checked, authorization process will be delayed.

❑ **Testosterone Injections (J1070 / J1071 / J3121)**	❑ **Aveed**® (testosterone undecanoate) **(J3145)**
❑ **TestoPel**® (testosterone pellets) **(11980 / S0189)**	

DRUG INFORMATION: Information must be completed or authorization process will be delayed.

Drug Name/Form: ______________________________ **Strength/Month:** ____________________

Dosing Schedule: ______________________________ **Length of Therapy:** ____________________

Diagnosis: ______________________________ **ICD Code:** ____________________

CLINICAL CRITERIA: To qualify, check applicable boxes below. If incomplete, authorization process will be delayed. All lab results must be attached.

- ❑ Patient has Partial Androgen Insensitivity Syndrome with male gender identity/gender dysphoria or delayed male puberty

OR

- ❑ Patient has hypogonadism confirmed by low testosterone levels:
  - ❑ **TWO** (2) MORNING **(6AM to 11AM)** testosterone levels ***within 6 months*** ***(attach lab results with reference ranges from the laboratory for both)***
    - ❑ First level: __________________________

    AND

    - ❑ Repeat testosterone or free testosterone level: ________________

    AND

    - ❑ Patient has the following symptoms (must attach chart notes documenting symptoms):

(continued on next page)

Specific symptoms (≥ 1 of the following) **AND**	**Non-Specific Symptoms** (≥ 2 of the following)
❑ Incomplete or delayed sexual development	❑ Decrease energy, motivation, initiative, and self-confidence
❑ Reduced sexual desire (libido) and activity	❑ Depressed mood
❑ Decreased spontaneous erections*	❑ Poor concentration and memory
❑ Breast discomfort, gynecomastia	❑ Sleep disturbance, increased sleepiness
❑ Loss of body (axillary, facial, and/or pubic) hair	❑ Mild anemia (Hgb 10-12)
❑ Small testes (<5 mL) or shrinking testes	❑ Reduced muscle bulk and strength Cachexia
❑ Low or zero sperm count	❑ Increased body fat, BMI
❑ Height loss, low trauma fracture, or low bone mineral density	❑ Diminished physical or work performance
❑ Hot flushes, sweats	

***If '*decreased spontaneous erections*' is the only symptom documented in chart notes, the request will be *denied* as testosterone replacement is *excluded* from coverage for sexual dysfunction.**

Note: ***For the hypogonadism indication, testosterone drugs cannot be used in conjunction with other erectile dysfunction drugs.***

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: ______________________________

Member Optima #: ______________________________ Date of Birth: ______________

Prescriber Name: ______________________________

Prescriber Signature: ______________________________ Date: ______________

Office Contact Name: ______________________________

Phone Number: ______________________________ Fax Number: ______________

DEA OR NPI #: ______________________________

REVISED/UPDATED: 7/1/2018