OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 1-800-750-9692

Check Drug Requested Below. If **NOT** checked, authorization might 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 may 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

(continued on next page)

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

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

*****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: ~~8/1/2017; 8/31/2018;~~ **10/8/2018**