OPTIMA HEALTH COMMUNITY CARE

(MEDICAID)

PHARMACY/MEDICAL 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?**

❑ **Yes** ❑ **No**

(NOT AVAILABLE AT SPECIALTY PHARMACY - PropriumRx and/or BriovaRx)

If YES, fax form to Optima Medical Services at 1-844-348-3720

❑ **Will Testosterone Replacement therapy be purchased by the member?**

❑ **Yes** ❑ **No**

(NOT AVAILABLE AT SPECIALTY PHARMACY – PropriumRx and/or BriovaRx)

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 **obtained on different dates (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	❑ 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: ~~8/1/2017~~; ~~8/31/2018~~; 10/8/2018; **2/5/2019**