OPTIMA HEALTH COMMUNITY CARE

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Testosterone Drugs - Non-Injectable (Medicaid)

DRUG REQUESTED*: *Applicable box below MUST be checked to qualify or authorization process will be delayed. Length of Authorization is ONE (1) Year.

PREFERRED	
❑ **Androgel® Gel Packet**	❑ **Androgel® Gel Pump**

NON-PREFERRED		
❑ **Androderm®** (patch)	❑ **Axiron®** (topical solution)	❑ **Fortesta™** (testosterone)
❑ **Natesto™ Nasal Gel**	❑ **Testim®**	❑ **Vogelxo™** gel/packet/pump
❑ **testosterone generic Androgel®**	❑ **testosterone gel/packet/pump generic for Vogelxo™**	❑ **testosterone generic for Fortesta™**

DRUG INFORMATION:* *Complete information below. If incomplete, authorization process will be delayed.

Drug Name: _____

Drug Form/Strength: _____ **Quantity per Day**: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

CLINICAL CRITERIA:* *ALL appropriate lines MUST be checked to qualify. Authorization process will be delayed if not completed. Attach lab results with this request form.

Initial Review Criteria:

- Member is 18 ≥ years old; **AND**
- Member is male; **AND**
- Member diagnosed with primary or secondary hypogonadism**; AND**
- Member does not have a history of prostate carcinoma or male breast carcinoma; **AND**
- Prescriber has submitted the results of **TWO** separate serum testosterone levels, each drawn in the morning which indicate a serum testosterone level below the normal range within the last 6 months
- Testosterone, normal range = 300 to 1,000 ng/dL
- ***Members who meet criteria should be approved for the Preferred drugs: AndroGel® Gel Packet OR AndroGel® Gel Pump first)***

Continuation of Therapy/Renewal Criteria

- Member has been compliant with treatment based on refill history
- Prescriber **MUST** submit labs indicating patient has a normal serum testosterone level on therapy (normal range 300-1,000 ng/dL) within the last 12 months

(signature on next page)

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: ~~12/25/2017:~~ **6/14/2018**