

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

- | | |
|--|--|
| <input type="checkbox"/> Androgel® Gel Packet | <input type="checkbox"/> Androgel® Gel Pump |
|--|--|

NON-PREFERRED

- | | | |
|---|--|---|
| <input type="checkbox"/> Androderm® (patch) | <input type="checkbox"/> Axiron® (topical solution) | <input type="checkbox"/> Fortesta™ (testosterone) |
| <input type="checkbox"/> Natesto™ Nasal Gel | <input type="checkbox"/> Testim® | <input type="checkbox"/> Vogelxo™ gel/packet/pump |
| <input type="checkbox"/> testosterone generic
Androgel® | <input type="checkbox"/> testosterone gel/packet/pump
generic for Vogelxo™ | <input type="checkbox"/> 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 submits labs indicating patient has a normal serum testosterone level on therapy (normal range 300-1,000 ng/dL) within the last 12 months
- Screen for steroid and opioid use

(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