

OPTIMA HEALTH PLAN

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 authorization process.

- Will Testosterone Replacement therapy be purchased by the Physician's office? (**NOT AVAILABLE AT SPECIALTY PHARMACY - BriovaRx**) Yes No
If YES, fax form to Optima Medical Services at 1-844-202-5034

- Will Testosterone Replacement therapy be purchased by the member? (**NOT AVAILABLE AT SPECIALTY PHARMACY - BriovaRx**) Yes No
If YES, fax form to: Optima Pharmacy Department at 1-800-750-9692

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

- | | |
|---|---|
| <input type="checkbox"/> TestoPel® (testosterone pellets)
(11980 / S0189) | <input type="checkbox"/> Aveed® (testosterone undecanoate) (J3145) |
|---|---|

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)

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

*Approved by the Pharmacy and Therapeutics Committee: 3/19/2014

REVISED/UPDATED: 10/31/2014; 12/23/2014; 12/26/2014; 3/17/2015; 4/8/2015; 5/23/2015; 7/29/15; 10/12/2015; 12/28/2015; 1/29/2016; 2/12/2016; 3/31/2016; 4/17/16; 5/6/2016; 11/29/2016; 12/26/2016; 9/18/2017; 10/4/2017; 1/24/2018