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 1-844-723-2094**

❑ **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.

❑ **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 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)

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 #: _____

***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**