MHS PHARMACY BENEFIT
TESTOSTERONES PRIOR AUTHORIZATION REQUEST FORM

MHS
550 N. Meridian St. Suite 101
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

Today's Date
__ __ / __ __ / __ __ __ __

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid #	Date of Birth __ / __ / __
Patient's Name	Prescriber's Name
Prescriber's IN License #	Specialty
Prescriber's NPI #	Prescriber's Signature
Return Fax # ___ - ___ - ____	Return Phone # ___ - ___ - ____
Check box if requesting retroactive PA ☐	Date(s) of service requested for retroactive eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Strength	Quantity	Dosage Regimen

INJECTABLE TESTOSTERONE AGENTS:

Please select one of the following:

- ☐ Member has a diagnosis of palliative treatment of breast cancer ☐ Yes ☐ No
  (Excluding Aveed, Testopel, and Xyosted)
- ☐ Member has a diagnosis of delayed puberty ☐ Yes ☐ No
- ☐ Total testosterone level is <= 350 ng/dL at therapy initiation (within the past 3 months) and <=1000 ng/dL at renewal (within the past 6 months) (Documentation is required) ☐ Yes ☐ No

TOPICAL TESTOSTERONE AGENTS:

1. Member is 16 years of age or older ☐ Yes ☐ No
2. Total testosterone level is <= 350 ng/dL at therapy initiation (within the past 3 months) or <=1000 ng/dL at renewal (within the past 6 months) (Documentation is required) ☐ Yes ☐ No

The following criteria must be met to <u>exceed</u> the established topical testosterone quantity limit:

1. Member has utilized topical testosterone therapy for at least 14 days ☐ Yes ☐ No
2. Total testosterone level after at least 14 days of therapy is <= 400ng/dL (within the last 3 months) (Documentation is required) ☐ Yes ☐ No

DANOCRINE (DANAZOL):

1. Member diagnosis(es):____
2. Does the member have any of the following contraindications to therapy? (Check all that apply.)
   - ☐ Active or history of thrombosis or thromboembolic disease
   - ☐ Androgen-dependent tumor
   - ☐ Cardiac disease
   - ☐ Porphyria
   - ☐ Pregnancy or breast-feeding
   - ☐ Severe hepatic disease
   - ☐ Severe renal disease
   - ☐ Undiagnosed genital bleeding

Note: Approvable diagnoses include autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, hereditary angioedema, and myelosclerosis with myeloid metaplasia.

JATENZO (TESTOSTERONE UNDECANOATE):

1. Member diagnosis(es):____
2. Member is 18 years of age or older ☐ Yes ☐ No
3. Does the member have any of the following contraindications to therapy? (Check all that apply.)
   - ☐ Breast cancer in men
   - ☐ Hypogonadal conditions not associated with structural or genetic etiologies
   - ☐ Pregnancy
   - ☐ Prostate cancer

Note: Approvable diagnoses include hypogonadism (documentation required of total testosterone <=350ng/dL at initiation [within past 3 months] or <=1000ng/dL at renewal [within past 6 months]).

Agents previously trialed: ____

Rationale for use of Jatenzo over injectable testosterone formulations AND Kyzatrex:

____

____

KYZATREX (TESTOSTERONE UNDECANOATE):

1. Member diagnosis(es):____
2. Member is 18 years of age or older ☐ Yes ☐ No
3. Does the member have any of the following contraindications to therapy? (Check all that apply.)
   - ☐ Breast cancer
   - ☐ Hypogonadal conditions not associated with structural or genetic etiologies
   - ☐ Pregnancy
   - ☐ Prostate cancer

Note: Approvable diagnoses include hypogonadism (documentation required of total testosterone <=350ng/dL at initiation [within past 3 months] or <=1000ng/dL at renewal [within past 6 months]).

Agents previously trialed: ____

Rationale for use of Kyzatrex over injectable testosterone formulations:

____

____

METHITEST (METHYLTESTOSTERONE):

1. Member diagnosis(es):____
2. Does the member have any of the following contraindications to therapy? (Check all that apply.)

☐ Breast cancer
☐ Pregnancy
☐ Prostate cancer

Note: Approvable diagnoses include hypogonadism (documentation required of total testosterone <=350ng/dL at initiation [within past 3 months] or <=1000ng/dL at renewal [within past 6 months]), delayed puberty, breast cancer, and cryptorchidism.

OXANDRIN (OXANDROLONE):

1. Member diagnosis(es):____
2. Does the member have any of the following contraindications to therapy? (Check all that apply.)

☐ Breast cancer
☐ Hypercalcemia
☐ Pregnancy
☐ Prostate cancer
☐ Severe renal disease

Note: Approvable diagnoses include adjunct treatment of severe burns during the catabolic and rehabilitative phases, AIDS-associated wasting syndrome, alcoholic hepatitis, cachexia.

TLANDO (TESTOSTERONE UNDECANOATE)

1. Member diagnosis(es):____
2. Member is 18 years of age or older ☐ Yes ☐ No
3. Does the member have any of the following contraindications to therapy? (Check all that apply.)

☐ Breast cancer
☐ Hypogonadal conditions not associated with structural or genetic etiologies
☐ Pregnancy
☐ Prostate cancer

Note: Approvable diagnoses include hypogonadism (documentation required of total testosterone <=350ng/dL at initiation [within past 3 months] or <=1000ng/dL at renewal [within past 6 months]).

Agents previously trialed: ____

Rationale for use of Tlando over injectable testosterone formulations AND Kyzatrex:

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