UnitedHealthcare Community Plan

Topical Testosterone Products
PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No

Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP Code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

Section C - Medical Information

Medication: **Strength:**

Directions for use: **Quantity:**

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? _____**

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information about this case, if any:

UnitedHealthcare Community Plan

Topical Testosterone Products
PRIOR AUTHORIZATION REQUEST FORM

Clinical and Drug Specific Information

- **Does the patient have a history of generic testosterone 1% topical gel? □ Yes □ No**
  If yes, list dates of therapy and reason for d/c: _____
  If no, is there a reason the patient cannot try this? _____
- **Has the patient been on any type of testosterone therapy before? □ Yes □ No**
  If yes, list therapy information: _____

Diagnosis of Hypogonadism:

- **Does the patient have two pre-treatment serum total testosterone levels less than 280 ng/dL (< 9.7 nmol/L) or less than the reference range for the lab, taken at separate times? □ Yes □ No**
  (If yes, supporting documentation must be attached)
  List 1st serum testosterone level and date:_____
  List 2nd serum testosterone level and date:_____
- **Does the patient have a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? □ Yes □ No**
  If yes, list condition: _____
- **Does the patient have one pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (< 5 ng/dL or < 0.17 nmol/L) or less than the reference range for the lab? □ Yes □ No**
  List free or bioavailable testosterone level and date:_____
- **Does the patient have a history of one of the following? □ Yes □ No (check all that apply)**
  □ Bilateral orchiectomy □ Panhypopituitarism □ A genetic disorder known to cause hypogonadism (list _____)
- **Is the patient taking any of the following? □ Yes □ No (check which applies)**
  □ One of the following growth hormones (unless diagnosed with panhypopituitarism):
  Genotropin, Humatrope, Norditropin FlexPro, Norditropin Nordiflex, Nutropin, Nutropin AQ, Omnitrope, Saisen, Tev-Tropin
  □ Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])
  If any, list medication or circle above: _____
- **Does the patient have one of the following: □ Yes □ No (check which applies)**
  □ Osteopenia □ Osteoporosis □ Decreased bone density □ Decreased libido
  □ Significant reduction in weight (less than 90% ideal body weight) (e.g., AIDS wasting syndrome)
  □ Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)

Requests for Female to Male Transsexual Persons:

- **Does the patient have a diagnosis of gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual and Mental Disorders (DSM)? □ Yes □ No**
- **Is the patient using hormones to change physical characteristics? □ Yes □ No**
- **Does the patient demonstrate knowledge of what hormones medically can and cannot do and their social benefits and risks? □ Yes □ No**
- **Does the patient have a documented real-life experience (living as the other gender) of at least three months prior to the administration of hormone? □ Yes □ No**
- **Did the patient have a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation? □ Yes □ No**
- **Does the patient have any significant medical or mental health concerns that are not well controlled? □ Yes □ No**

(questions continued on next page)

UnitedHealthcare Community Plan

Topical Testosterone Products
PRIOR AUTHORIZATION REQUEST FORM

- **Is the patient taking any of the following? □ Yes □ No (check which applies)**

□ One of the following growth hormones (unless diagnosed with panhypopituitarism):

Genotropin, Humatrope, Norditropin FlexPro, Norditropin Nordiflex, Nutropin, Nutropin AQ, Omnitrope, Saisen, Tev-Tropin

□ Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])

If any, list medication or circle above: _____

Requests for Continuation of Therapy:

- Is this the patient's first time continuing treatment? □ Yes □ No

- Does the patient have one of the following? □ Yes □ No (documentation of lab value and date must be attached)

□ Follow-up total serum testosterone level drawn within the past 6 months is within or below the normal limits of the reporting lab

□ Follow-up total serum testosterone level drawn within the past 6 months is outside of upper limits of normal for the reporting lab and the dose is adjusted

- o Check which applies, serum testosterone level and date: _____

- Does the patient have one of the following? □ Yes □ No (documentation of lab value and date must be attached)

□ Follow-up calculated free or bioavailable testosterone level drawn within the past 6 months is within or below the normal limits of the reporting lab

□ Follow-up calculated free or bioavailable testosterone level drawn within the past 6 months is outside of upper limits of normal for the reporting lab and the dose is adjusted

- o Check which applies, serum testosterone level and date: _____

- Does the patient have one of the following? □ Yes □ No (documentation of lab value and date must be attached)

□ Follow-up total serum testosterone level drawn within the past 12 months is within or below the normal limits of the reporting lab

□ Follow-up total serum testosterone level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted

- o Check which applies, serum testosterone level and date: _____

- Does the patient have one of the following? □ Yes □ No (documentation of lab value and date must be attached)

□ Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is within or below the normal limits of the reporting lab

□ Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted

- o Check which applies, serum testosterone level and date: _____

- **Does the patient have a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)? □ Yes □ No**

If yes, list condition: _____

- **Is the patient taking any of the following? □ Yes □ No (check which applies)**

□ One of the following growth hormones (unless diagnosed with panhypopituitarism):

Genotropin, Humatrope, Norditropin FlexPro, Norditropin Nordiflex, Nutropin, Nutropin AQ, Omnitrope, Saisen, Tev-Tropin

□ Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])

If any, list medication or circle above: _____

Physician Signature: _____ **Date:** _____