## **TESTOSTERONES PRIOR AUTHORIZATION REQUEST FORM**



## OptumRx P.O. Box 25184 Santa Ana, CA, 92799 Phone: (800) 310-6826 Fax: (866) 577-6384





		Community Plan
Today's Date		
Note: This form must be completed by the prescribin	ng provider.	
**All sections must be complete	d or the request	will be returned**
Patient's Medicaid #	Date of Birth	
Patient's Name	Prescriber's Nan	ne
Prescriber's IN License #	Specialty	
Prescriber's NPI #	Prescriber's Sigr	nature
Return Fax #	Return Phone #	
Check box if requesting retro-active PA	Date(s) of servic retro-active eligit	e requested for oility (if applicable):
Note: Submit PA requests for retroactive claims (dates of service eligibility timelines) with dates of service prior to 30 calendar days or less and going forward).		
Requested Medication Strength	Quantity	Dosage Regimen
DEPO-TESTOSTERONE, TESTOSTERONE CYPIONA	ATE	
Initial Authorization:  1. Please select one of the following:		
Please select one of the following:     Member has a diagnosis of delayed puberty		
Please select one of the following:	dL within the past	3 months (Documentation is required)
Please select one of the following:     Member has a diagnosis of delayed puberty	dL within the past	3 months (Documentation is required)
Please select one of the following:		
<ol> <li>Please select one of the following:         <ul> <li>Member has a diagnosis of delayed puberty</li> <li>Member has a total testosterone level ≤ 350 ng/c</li> </ul> </li> <li>For ALL indications:         <ul> <li>Provider attests that member has none of the followi</li> <li>Breast cancer in a member assigned male a</li> </ul> </li> </ol>	ng contraindicatio	
<ol> <li>Please select one of the following:         <ul> <li>Member has a diagnosis of delayed puberty</li> <li>Member has a total testosterone level ≤ 350 ng/c</li> </ul> </li> <li>For ALL indications:         <ul> <li>Provider attests that member has none of the following:</li> </ul> </li> </ol>	ng contraindicatio	
<ol> <li>Please select one of the following:         <ul> <li>Member has a diagnosis of delayed puberty</li> <li>Member has a total testosterone level ≤ 350 ng/c</li> </ul> </li> <li>For ALL indications:         <ul> <li>Provider attests that member has none of the followi</li> <li>Breast cancer in a member assigned male a</li> <li>Pregnancy</li> <li>Prostate cancer</li> </ul> </li> </ol>	ng contraindication	ons to therapy: □ Yes □ No
<ol> <li>Please select one of the following:         <ul> <li>Member has a diagnosis of delayed puberty</li> <li>Member has a total testosterone level ≤ 350 ng/c</li> </ul> </li> <li>For ALL indications:         <ul> <li>Provider attests that member has none of the followi</li> <li>Breast cancer in a member assigned male a</li> <li>Pregnancy</li> </ul> </li> </ol>	ng contraindication	ons to therapy: □ Yes □ No
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<ol> <li>Please select one of the following:         <ul> <li>Member has a diagnosis of delayed puberty</li> <li>Member has a total testosterone level ≤ 350 ng/c</li> </ul> </li> <li>For ALL indications:         <ul> <li>Provider attests that member has none of the followi</li> <li>Breast cancer in a member assigned male a</li> <li>Pregnancy</li> <li>Prostate cancer</li> </ul> </li> </ol>	ing contraindication of birth al rationale for us	ons to therapy: □ Yes □ No e:

Reauthorization:  1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) □ Yes □ No
2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above ☐ Yes ☐ No
If <b>no</b> , please specify contraindication and medical rationale for use:
TESTOSTERONE ENANTHATE
Initial Authorization:  1. Please select one of the following:
<ul> <li>Member has a diagnosis of delayed puberty</li> <li>Has the member had a previous trial and failure of ALL preferred injectable testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial</li> </ul>
(reference PA criteria)? □ Yes □ No
If <b>no</b> , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
<ul> <li>Member has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required)</li> <li>Has the member had a previous trial and failure of ALL preferred injectable testosterone agents (reference PA criteria)? ☐ Yes ☐ No</li> <li>If no, please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:</li> </ul>
<ul> <li>☐ Member needs medication for palliative treatment of metastatic breast cancer</li> <li>2. For ALL indications:         Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No         • Breast cancer in a member assigned male at birth     </li> </ul>
<ul><li>Pregnancy</li><li>Prostate cancer</li></ul>
If <b>no</b> , please specify contraindication and medical rationale for use:
Note: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply.
Reauthorization:  1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) □ Yes □ No
2. Has the member had a previous trial and failure of at least ONE preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (not required for palliative treatment of breast cancer) [reference PA criteria]?   Yes  No

If <b>no</b> , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
3. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above $\square$ Yes $\square$ No
If <b>no</b> , please specify contraindication and medical rationale for use:
AVEED, AZMIRO, TESTOPEL PELLET, XYSOTED
Initial Authorization:
1. Please select one of the following:
☐ Member has a diagnosis of delayed puberty
<ul> <li>Has the member had a previous trial and failure of ALL preferred injectable testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria)?</li></ul>
If <b>no</b> , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
<ul> <li>Member has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required)</li> <li>Has the member had a previous trial and failure of ALL preferred injectable testosterone agents (reference PA criteria)? ☐ Yes ☐ No</li> <li>If no, please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:</li> </ul>
2. For <b>ALL</b> indications:  Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No  • Breast cancer in a member assigned male at birth  • Hypogonadal conditions not associated with structural or genetic etiologies (Xyosted ONLY)  • Pregnancy  • Prostate cancer  If <b>no</b> , please specify contraindication and medical rationale for use:
Note: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply
Reauthorization:
1. Total testosterone level is ≤1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Has the member had a previous trial and failure of at least ONE preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria)?   Yes  No

If <b>no</b> , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
3. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above ☐ Yes ☐ No
If <b>no</b> , please specify contraindication and medical rationale for use:
ANDRODERM, TESTOSTERONE 1% (25 MG)/ 2.5 GM GEL PACKETS, TESTOSTERONE 1% (50 MG)/5 GM GEL PACKETS, TESTOSTERONE 1% (12.5 MG)/ACT GEL PUMP, TESTOSTERONE 1.62% (20.25 MG)/ACT METERED PUMP GEL, TESTIM 1% (50 MG)/5 GM GEL TUBES
Initial Authorization:  1. Please select one of the following:  ☐ Member is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past 3 months  (Documentation is required), and is requesting to use topical testosterone within the established quantity
limits ☐ Yes ☐ No  Requested dose:
<ul> <li>Member is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical testosterone therapy (Documentation is required) and is requesting to exceed established quantity limits </li> <li>Yes □ No</li> </ul>
Requested dose:
Member has utilized ≥ 14 days of topical testosterone therapy: ☐ Yes ☐ No
Name of medication:  Dose:
Start and End date:
If <b>no</b> , please provide medical justification as to why member is requesting a dose beyond established quantity limits:
2. For <b>ALL</b> indications:  Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No  • Breast cancer in a member assigned male at birth  • Pregnancy  • Prostate cancer
If <b>no</b> , please specify contraindication and medical rationale for use:
Note: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply

2. Provide	er attests that member remains a candidate for treatment, indicating that they have not developed any
	traindication(s) listed under initial authorization above  Yes  No
If	no, please specify contraindication and medical rationale for use:
	se requested for reauthorization should not exceed established quantity limits unless member ly has been approved to exceed the established quantity limits
Reque	sted dose:
NATEST	D, TESTOSTERONE 1% (50 MG)/5 GM GEL TUBES, TESTOSTERONE 1.62% (40.5 MG)/2.5 GM
GEL PAC MG)/ACT	KETS, TESTOSTERONE 1.62% (20.25 MG)/1.25 GM GEL PACKETS, TESTOSTERONE 2% (10 METERED PUMP, TESTOSTERONE 30 MG/ACT SOLUTION, VOGELXO 1% (50 MG)/5 GM GEL S, VOGELXO 1% (12.5 MG)/ACT GEL PUMP
	thorization: select one of the following:
□ Me	ember is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past 3 months
,	cumentation is required), and is requesting to use topical testosterone within the established quantity lits $\square$ Yes $\square$ No
	Demiserad deser
	Requested dose:
tes	Requested dose:  ember is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical stosterone therapy (Documentation is required) and is requesting to exceed established quantity limits Yes □ No  Requested dose:
tes	ember is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical stosterone therapy (Documentation is required) and is requesting to exceed established quantity limits Yes □ No  Requested dose:
tes	ember is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical stosterone therapy (Documentation is required) and is requesting to exceed established quantity limits  Yes □ No  Requested dose:  Member has utilized ≥ 14 days of topical testosterone therapy: □ Yes □ No
tes	ember is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical stosterone therapy (Documentation is required) and is requesting to exceed established quantity limits Yes □ No  Requested dose:  Member has utilized ≥ 14 days of topical testosterone therapy: □ Yes □ No  Name of medication:
tes	ember is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical stosterone therapy (Documentation is required) and is requesting to exceed established quantity limits  Yes □ No  Requested dose:  Member has utilized ≥ 14 days of topical testosterone therapy: □ Yes □ No
tes	ember is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical stosterone therapy (Documentation is required) and is requesting to exceed established quantity limits Yes □ No  Requested dose:  Member has utilized ≥ 14 days of topical testosterone therapy: □ Yes □ No  Name of medication:  Dose:
tes	ember is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical stosterone therapy (Documentation is required) and is requesting to exceed established quantity limits. Yes □ No  Requested dose:  Member has utilized ≥ 14 days of topical testosterone therapy: □ Yes □ No  Name of medication:  Dose:  Start and End date:  If no, please provide medical justification as to why member is requesting a dose beyond establishe
tes	ember is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical stosterone therapy (Documentation is required) and is requesting to exceed established quantity limits. Yes □ No  Requested dose:  Member has utilized ≥ 14 days of topical testosterone therapy: □ Yes □ No  Name of medication:  Dose:  Start and End date:  If no, please provide medical justification as to why member is requesting a dose beyond establishe

Provider attests that member has none of the following contraindications to therapy:   Yes  No
Dan 4
Breast cancer in a member assigned male at birth
Pregnancy
Prostate cancer
If <b>no</b> , please specify contraindication and medical rationale for use:
Note: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply
Reauthorization:
1. Total testosterone level is ≤1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Previous trial and failure of at least ONE preferred topical testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) $\square$ Yes $\square$ No
If <b>no</b> , please provide medical justification for use of requested agent over ALL preferred topical testosterone agents:
<ol> <li>Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above ☐ Yes ☐ No</li> <li>If no, please specify contraindication and medical rationale for use:</li> </ol>
Note: dose requested for reauthorization should not exceed established quantity limits unless member historically has been approved to exceed the established quantity limits  Requested dose:
historically has been approved to exceed the established quantity limits  Requested dose:
historically has been approved to exceed the established quantity limits  Requested dose:  DANAZOL:
historically has been approved to exceed the established quantity limits  Requested dose:
historically has been approved to exceed the established quantity limits  Requested dose:  DANAZOL:
historically has been approved to exceed the established quantity limits  Requested dose:  DANAZOL: Initial Authorization (approval up to 6 months):
historically has been approved to exceed the established quantity limits  Requested dose:  DANAZOL:  Initial Authorization (approval up to 6 months):  1. Member diagnosis(es):  Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia
historically has been approved to exceed the established quantity limits  Requested dose:  DANAZOL:  Initial Authorization (approval up to 6 months):  1. Member diagnosis(es):  Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia  2. For ALL indications:
historically has been approved to exceed the established quantity limits  Requested dose:
historically has been approved to exceed the established quantity limits  Requested dose:  DANAZOL:  Initial Authorization (approval up to 6 months):  1. Member diagnosis(es):  Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia  2. For ALL indications:  Provider attests that member has none of the following contraindications to therapy:   Yes  No  Active or history of thrombosis or thromboembolic disease
historically has been approved to exceed the established quantity limits  Requested dose:
historically has been approved to exceed the established quantity limits  Requested dose:
historically has been approved to exceed the established quantity limits  Requested dose:  DANAZOL:  Initial Authorization (approval up to 6 months):  1. Member diagnosis(es):  Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia  2. For ALL indications:  Provider attests that member has none of the following contraindications to therapy:   • Active or history of thrombosis or thromboembolic disease  • Androgen-dependent tumor  • Cardiac disease  • Porphyria
historically has been approved to exceed the established quantity limits  Requested dose:  DANAZOL:  Initial Authorization (approval up to 6 months):  1. Member diagnosis(es):  Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia  2. For ALL indications:  Provider attests that member has none of the following contraindications to therapy:   • Active or history of thrombosis or thromboembolic disease  • Androgen-dependent tumor  • Cardiac disease  • Porphyria  • Pregnancy or breast-feeding
historically has been approved to exceed the established quantity limits  Requested dose:  DANAZOL:  Initial Authorization (approval up to 6 months):  1. Member diagnosis(es):  Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia  2. For ALL indications:  Provider attests that member has none of the following contraindications to therapy:   Active or history of thrombosis or thromboembolic disease  Androgen-dependent tumor  Cardiac disease  Porphyria  Pregnancy or breast-feeding  Severe hepatic disease
historically has been approved to exceed the established quantity limits  Requested dose:  DANAZOL:  Initial Authorization (approval up to 6 months):  1. Member diagnosis(es):  Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia  2. For ALL indications:  Provider attests that member has none of the following contraindications to therapy:   • Active or history of thrombosis or thromboembolic disease  • Androgen-dependent tumor  • Cardiac disease  • Porphyria  • Pregnancy or breast-feeding

Reauthorization (approval up to 6 months):  1. Documentation from prescriber indicating continued benefit from the medication without sign	·
1 Documentation from prescriber indicating continued benefit from the medication without sign	
adverse events	ificant
2. Provider attests that member remains a candidate for treatment, indicating that they have no the contraindication(s) listed under initial authorization above $\square$ Yes $\square$ No	ot developed any of
If <b>no</b> , please specify contraindication and medical rationale for use:	
JATENZO (TESTOSTERONE UNDECANOATE):	
Initial Authorization:  1. Member is 18 years of age or older and is requesting to use oral testosterone within the est limits ☐ Yes ☐ No  Requested dose:	tablished quantity
<ol> <li>Member has a diagnosis of hypogonadism with a total testosterone level ≤ 350 ng/dL within to (Documentation is required)</li></ol>	ed by claims ia) □ Yes □ No
<ul> <li>4. For ALL indications: Provider attests that member has none of the following contraindications to therapy: □ Yes <ul> <li>Breast cancer in a member assigned male at birth</li> <li>Hypogonadal conditions not associated with structural or genetic etiologies</li> <li>Pregnancy</li> <li>Prostate cancer</li> </ul> </li> <li>If no, please specify contraindication and medical rationale for use:</li> </ul>	s □ No
Reauthorization:	
<ol> <li>Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required)</li> <li>Provider attests that member remains a candidate for treatment, indicating that they have no the contraindication(s) listed under initial authorization above □ Yes □ No</li> </ol>	

3. Previous trial and failure of at least ONE preferred in	ectable testosterone agent , as confirmed by claims
history, chart documentation, or provider attestation inc	
Yes No	during dates of that (reference 177 official)
	of requested agent over ALL preferred injectable
testosterone agents:	
Note: dose requested for reauthorization should no	avecad actablished quantity limits
Note. dose requested for reautiforization should no	exceed established qualitity lilling
Damus stad dasas	
Requested dose:	
METHITEOT (METHINI TEOTOOTEDONE)	
METHITEST (METHYLTESTOSTERONE)	
Initial Authorization (approval up to 6 months):	
1. Please select one of the following:	
☐ Member has a diagnosis of cryptorchidism	
☐ Member has a diagnosis of delayed puberty	
☐ Member has a diagnosis of hypogonadism (prin	ary or hypogonadotropic) with a total testosterone
≤ 350 ng/dL within the past 3 months (Documenta	, ,
·	
☐ Member needs medication for palliative treatme	nt of metastatic dreast cancer
2. Previous trial and failure of at least ONE preferred inj	ectable testosterone agent, as confirmed by claims
history, chart documentation, or provider attestation inc	uding dates of trial (reference PA criteria) $\square$ Yes $\square$ No
, ; ;	aung autos er anar (reference i i refinance) — ree — me
If a second constitution of the second constitut	of a constant and a constant of the first state of
	of requested agent over ALL preferred injectable
testosterone agents:	
3. For <b>ALL</b> indications:	
5.1 Of ALL Indications.	
Provider attests that member has none of the follow	ing contraindications to therapy: ☐ Yes ☐ No
Breast cancer in a member assigned male a	.,
_	at Dil ti i
<ul> <li>Pregnancy</li> </ul>	
<ul> <li>Prostate cancer</li> </ul>	
If <b>no</b> , please specify contraindication and medication	ıl rationale for use:
-71 1 7	
	<del> </del>
4. Dose requested of methyltestosterone is within the	established quantity limits
1. Bood requested of methyllostesterone to within the	otabilotion qualitity illinto
Requested dose:	☐ Yes ☐ No
	<del></del>
Poputhorization (approval up to 6 months):	
Reauthorization (approval up to 6 months):	
Please select one of the following:	
$\ \square$ Member has a diagnosis of hypogonadism and a	total testosterone level ≤ 1000 ng/dL within the past 6
months (Documentation is required)	
. ,	
☐ Member has a diagnosis of delayed puberty, pal	
	cumentation indicating continued benefit from the
medication without significant adverse events:	
,	

2. For <b>ALL</b> indications:
Provider attests that member remains a candidate for treatment, indicating that they have not developed any
of the contraindication(s) listed under initial authorization above $\square$ Yes $\ \square$ No
If <b>no</b> , please specify contraindication and medical rationale for use:
<del></del>
3. Previous trial and failure of at least ONE preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) $\square$ Yes $\square$ No
If <b>no</b> , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
Note: dose requested for reauthorization should not exceed established quantity limits
Requested dose:
TLANDO (TESTOSTERONE UNDECANOATE)
<ul> <li>Initial Authorization:</li> <li>1. Member is 18 years of age or older and is requesting to use oral testosterone within the established quantity limits ☐ Yes ☐ No</li> </ul>
Requested dose:
2. Member has a diagnosis of hypogonadism and a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) ☐ Yes ☐ No
3. Previous trial and failure of at least ONE preferred injectable testosterone agent , as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) $\square$ Yes $\square$ No
If <b>no</b> , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
4. For <b>ALL</b> indications:
Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No  ■ Breast cancer
<ul> <li>Hypogonadal conditions not associated with structural or genetic etiologies</li> </ul>
<ul><li>Pregnancy</li><li>Prostate cancer</li></ul>
If <b>no</b> , please specify contraindication and medical rationale for use:

Reauthorization:  1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Prescriber attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above $\square$ Yes $\square$ No
If <b>no</b> , please specify contraindication and medical rationale for use:
3. Previous trial and failure of at least ONE preferred injectable testosterone agent , as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) $\square$ Yes $\square$ No
If <b>no</b> , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
Note: dose requested for reauthorization should not exceed established quantity limits  Requested dose:
UNDECATREX (TESTOSTERONE UNDECANOATE):
Initial Authorization:  1. Member is 18 years of age or older and is requesting to use oral testosterone within the established quantity limits   Yes  No  Requested dose:
2. Member has a diagnosis of hypogonadism with a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) ☐ Yes ☐ No
3. Previous trial and failure of BOTH Jatenzo AND Tlando, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria) $\square$ Yes $\square$ No
If <b>no</b> , please provide medical justification for use of requested agent over Jatenzo AND Tlando:
4. For ALL indications:  Provider attests that member has none of the following contraindications to therapy: □ Yes □ No  ■ Breast cancer in a member assigned male at birth  ■ Hypogonadal conditions not associated with structural or genetic etiologies  ■ Pregnancy  ■ Prostate cancer  If no, please specify contraindication and medical rationale for use:
Reauthorization:
1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above $\square$ Yes $\square$ No

	ous trial and failure of BOTH Jatenzo AND Tlando, as confirmed by claims history, chart documentation
·	der attestation including dates of trial (reference PA criteria) $^{\prime}$ es $\;\square$ No
I	f <b>no</b> , please provide medical justification for use of requested agent over Jatenzo AND Tlando:
-	
ote: d	ose requested for reauthorization should not exceed established quantity limits

## CONFIDENTIAL INFORMATION

This facsimile transmission (and attachments) may contain protected health information from the Indiana Health Coverage Programs (IHCP), which is intended only for the use of the individual or entity named in this transmission sheet. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.