UnitedHealthcare Community Plan

Testosterone
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 may contain 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 Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider 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

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ Yes □ No	**Does the patient have either of the following diagnoses?** *(If yes, check which applies)* □ Hypogonadism □ Gender Dysphoria
□ Yes □ No	**Is the patient taking any of the following:** *(If yes, complete Section D above)* □ One of the following growth hormones (unless diagnosed with panhypopituitarism): - Genotropin, Humatrope, Norditropin FlexPro, Nutropin AQ, Omnitrope, Saizen □ Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to generic testosterone 1% topical gel? (If yes, complete Section D above)**
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to testosterone cypionate injection (generic Depo-Testosterone)? (If yes, complete Section D above)**
□ Yes □ No	**Does the patient have a history of failure or rationale for not being able to use intramuscular testosterone enanthate injection (generic Delatestryl)? (If yes, complete Section D above)**
HYPOGONADISM	
□ Yes □ No	**Was the patient male at birth?**
Document 1st pre-treatment serum total testosterone: ng/dL **Document 2nd pre-treatment serum total testosterone: ng/dL**	
□ Yes □ No	**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)?** *If yes, list condition:*
□ Yes □ No	**Does the patient have one pre-treatment calculated free or bioavailable testosterone level?** *If yes, document lab value and date of both levels:*
□ Yes □ No	**Does the patient have a history of one of the following:** *(If yes, check which applies)* □ Bilateral orchiectomy □ Panhypopituitarism □ A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)
□ Yes □ No	**Does the patient have one of the following:** *(If yes, 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)
GENDER DYSPHORIA	
□ Yes □ No	**Is the patient's diagnosis of gender dysphoria defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)?**
□ Yes □ No	**Is the patient using hormones to change physical characteristics?**
CONTINUATION OF THERAPY	
□ Yes □ No	**Has the patient had follow-up total serum testosterone level drawn within the past 12 months?** *If yes, list value and date:*
□ Yes □ No	**If the total serum testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab, has the dose been adjusted?**
□ Yes □ No	**Has the patient had follow-up calculated free or bioavailable testosterone level drawn within the past 12 months, with one of the following results?** *If yes, list value and date:*
□ Yes □ No	**If the calculated free of bioavailable testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab, has the dose been adjusted?**
□ Yes □ No	**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)?**

Provider Signature: _____ **Date:** _____