

**Please print – accuracy is important.**

**Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.**

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for testosterone products. Payment will be considered with documentation of a specific testicular or hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism. Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis. Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for erectile dysfunction, infertility, and age-related hypogonadism will not be considered. Payment will be considered under the following conditions:

- 1) Patient is male and 18 years of age or older (or 12 years of age and older for testosterone cypionate); and
- 2) Patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (attach results); and
- 3) Patient has primary hypogonadism or hypogonadotropic hypogonadism (further defined below):
  - Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following: cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, toxic damage from alcohol or heavy metals.
  - Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency, pituitary-hypothalamic injury from tumors, trauma, or radiation.
- 4) Patient does not have:
  - Breast or prostate cancer.
  - Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL.
  - Hematocrit > 50%.
  - Untreated severe obstructive sleep apnea.
  - Severe lower urinary tract symptoms.
  - Uncontrolled or poorly controlled heart failure.

If criteria for coverage are met, initial authorizations will be given for three months. Requests for continuation of therapy will require the following:

- An updated testosterone level (attach result); and
- Documentation the patient has not experienced a hematocrit > 54% or an increase in PSA > 1.4ng/mL in the past 12 months.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult [www.iowamedicaidpdl.com/pa\\_criteria](http://www.iowamedicaidpdl.com/pa_criteria).

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**Preferred:**

- Androderm
- Androgel 1% packets
- Methyltestosterone
- Testim

**Non-Preferred:**

- Testosterone cypionate
- Testosterone enanthate
- Androgel 1.62% packets
- Androgel pump
- Android
- Aveed
- Axiron
- Depo-Testosterone
- Fortesta
- Methitest
- Natesto
- Striant
- Testred
- Testosterone gel
- Vogelxo

Strength: \_\_\_\_\_ Dosage Instructions: \_\_\_\_\_ Quantity: \_\_\_\_\_ Days Supply: \_\_\_\_\_

**Complete for diagnosis of hypogonadism:**

**Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:**

- Cryptorchidism     Bilateral torsion     Orchitis     Vanishing testes syndrome     Orchiectomy
- Klinefelter’s syndrome     Chemotherapy     Toxic damage from alcohol or heavy metals
- Other: \_\_\_\_\_

**Hypogonadotropic hypogonadism:**

- Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency
- Pituitary-hypothalamic injury from tumors, trauma, or radiation

**List and attach results of two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used:**

Level 1: \_\_\_\_\_ Date: \_\_\_\_\_ Level 2: \_\_\_\_\_ Date: \_\_\_\_\_

**Does patient have any of the following:**

- Breast or prostate cancer:  Yes     No
- Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL:  Yes     No
- Hematocrit > 50%:  Yes     No
- Untreated severe obstructive sleep apnea:  Yes     No
- Severe lower urinary tract symptoms:  Yes     No
- Uncontrolled or poorly controlled heart failure:  Yes     No

**Renewal requests:**

List and attach updated testosterone level: \_\_\_\_\_ Level: \_\_\_\_\_ Date: \_\_\_\_\_

**Has patient experienced the following in the past 12 months:**

- Hematocrit > 54%:  Yes     No                      Most recent lab date: \_\_\_\_\_
- Increase in PSA > 1.4ng/mL:  Yes     No                      Most recent lab date: \_\_\_\_\_

Other medical conditions to consider: \_\_\_\_\_

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**Attach lab results and other documentation as necessary.**

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature:  
(Must match prescriber listed above.)

Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check [www.amerihealthcaritasia.com/Provider](http://www.amerihealthcaritasia.com/Provider) to confirm your version of this form.