ATRIO HEALTH PLANS

Androgenic Agents
TESTOPEL (testosterone pellets) S0189
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**NEW START - Start Date:_____**	☐	**Continuation** (within 365 days)**:** Date of last treatment _____
☐	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug ☐ Self-administered	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____ **Date:**_____ **/**____ **/**____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Androgenic Agents PA

Drug Name(s):
TESTOPEL
TESTOSTERONE

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:
N/A

Prescriber Restrictions:
N/A

Coverage Duration:
Approval will be for 12 months

FDA Indications:
TESTOPEL

- Replacement therapy in congenital or acquired conditions associated with a deficiency or absence of endogenous testosterone
    - Primary hypogonadism (congenital or acquired) - testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome; or orchiectomy
    - Hypogonadotropic hypogonadism (congenital or acquired) - gonadotropic LHRH deficiency, or pituitary - hypothalamic injury from tumors, trauma or radiation

Off-Label Uses:
TESTOPEL

- Female-to-male transsexual - Gender dysphoria
- Osteoporosis, Male
- Weight gain

Age Restrictions:
Can be used in adolescents: Female-to-male transsexual - Gender dysphoria

Other Clinical Considerations:
TESTOPEL – Contraindications:

- Breast cancer, male
- Females who are pregnant, may become pregnant, or who are breastfeeding; known teratogen; exposure of female fetus or nursing infant to testosterone residue may result in varying degrees of virilization
- Hypersensitivity to testosterone or any component of the product
- Prostate cancer, known or suspected
- Use in women

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/F0EAB7/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/0639FA/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Testosterone&fromInterSaltBase=true&UserMdxSearchTerm=%24userMdxSearchTerm&false=null&=null#