US Family Health Plan

Prior Authorization Request Form for

Androderm, AndroGel, Axiron, Natesto, Striant, Testim, Testosterone 1% & 1.62% gel, Vogelxo, Xyosted

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 — Medication requested:

Step 2 — Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: _____ Secure Fax #: _____

Step 3 — Please complete the clinical assessment:

1. Is the requested medication being used for female-to-male gender reassignment (endocrinologic masculinization)?	☐ Yes **SKIP to question 10**	☐ No **Proceed to question 2**
2. Is the patient a male who is greater than 17 years of age?	☐ Yes **Proceed to question 3**	☐ No **Coverage not approved**
3. Does the patient have a diagnosis of hypogonadism as evidenced by 2 or more morning total testosterone levels below 300 ng/dL ?	☐ Yes **Proceed to question 4**	☐ No **Coverage not approved**
4. Is the patient experiencing symptoms usually associated with hypogonadism?	☐ Yes **Proceed to question 5**	☐ No **Coverage not approved**
5. Is this request for Xyosted?	☐ Yes **Proceed to question 6**	☐ No **Proceed to question 9**
6. Will Xyosted be used concomitantly with other testosterones?	☐ Yes **Coverage not approved**	☐ No **Proceed to question 7**
7. Is Xyosted being prescribed for the treatment of men with hypogonadal conditions associated with structural or genetic etiologies?	☐ Yes **Proceed to question 8**	☐ No **Coverage not approved**
8. Has the provider considered the patient's baseline cardiovascular risk and ensured blood pressure is adequately controlled before initiating Xyosted and periodically during the course of treatment (based on the product's boxed warning of increased risk of major adverse cardiovascular events and hypertension)?	☐ Yes **Proceed to question 9**	☐ No **Coverage not approved**
9. Has the patient tried Fortesta (testosterone 2% gel) AND generic testosterone ethanthate injection for a minimum of 90 days AND failed to achieve total serum testosterone levels above 400 ng/dL (labs drawn 2 hours after Fortesta application or testosterone enanthate injection) AND without improvement in symptoms?	☐ Yes **Sign and date on page 2**	☐ No **SKIP to question 17**

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10. Does the patient have a diagnosis of gender dysphoria made by a TRICARE-authorized mental health provider according to most current edition of the DSM?	☐ Yes **Proceed to question 11**	☐ No **Coverage not approved**
11. Is the patient 16 years of age or older?	☐ Yes **Proceed to question 12**	☐ No **Coverage not approved**
12. Is the patient a biological female of childbearing potential?	☐ Yes **Proceed to question 13**	☐ No **SKIP to question 14**
13. Is the patient pregnant or breastfeeding	☐ Yes **Coverage not approved**	☐ No **Proceed to question 14**
14. Has the patient experienced puberty to at least Tanner stage 2?	☐ Yes **Proceed to question 15**	☐ No **Coverage not approved**
15. Does the patient have psychiatric comorbidity that would confound a diagnosis of gender dysphoria or interfere with treatment (for example: unresolved body dysmorphic disorder; schizophrenia or other psychotic disorders that have not been stabilized with treatment)?	☐ Yes **Coverage not approved**	☐ No **Proceed to question 16**
16. Does the patient have a documented minimum of three months of real-life experience (RLE) and/or three months of continuous psychotherapy addressing gender transition as an intervention for gender dysphoria?	☐ Yes **Proceed to question 21**	☐ No **Coverage not approved**
17. Does the patient have a contraindication or relative contraindication to Fortesta (and also testosterone enanthate injection, if requesting Xyosted) that does not apply to the requested agent?	☐ Yes **Sign and date below**	☐ No **Proceed to question 18**
18. Has the patient experienced a clinically significant skin reaction to Fortesta that is not expected to occur with the requested agent?	☐ Yes **Sign and date below**	☐ No **Proceed to question 19**
19. Is the request for Androderm, Natesto, Striant or Xyosted?	☐ Yes **Proceed to question 20**	☐ No **Coverage not approved**
20. Does the patient require a testosterone replacement therapy that has a low risk of skin-to-skin transfer between family members?	☐ Yes **Sign and date below**	☐ No **Coverage not approved**
21. Does the patient have a contraindication or relative contraindication to Fortesta (and also testosterone enanthate injection, if requesting Xyosted) that does not apply to the requested agent?	☐ Yes **Sign and date below**	☐ No **Proceed to question 22**
22. Has the patient experienced a clinically significant skin reaction to Fortesta that is not expected to occur with the requested agent?	☐ Yes **Sign and date below**	☐ No **Proceed to question 23**
23. Is the request for Androderm, Natesto, Striant, Xyosted?	☐ Yes **Proceed to question 24**	☐ No **Coverage not approved**
24. Does the patient require a testosterone replacement therapy that has a low risk of skin-to-skin transfer between family members?	☐ Yes **Sign and date below**	☐ No **Coverage not approved**

Step 4

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____