US Family Health Plan Prior Authorization Request Form for

Androderm, Fortesta (2% testosterone gel multi-dose pump (MDP)), Natesto, Testosterone 1% gel packet, Vogelxo (MDP, gel packet)

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 855-273-5735

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Initial therapy approves for 1 year, renewal approves indefinitely. For renewal of therapy, an initial Tricare prior authorization approval is required. Clinical documentation and lab work may be required

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. Will the requested medication be used to enhance athletic performance?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Will the requested medication be used in combination with other testosterone products?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes Proceed to question **4**	☐ No Proceed to question **8**
4. What is the indication or diagnosis?	☐ Hypogonadism - Proceed to question **6** ☐ Female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth) - Proceed to question **5** ☐ Other - Proceed to question **6**	
5. Is the patient 19 years of age or older?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

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6. Has the patient had a positive response to therapy?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Do the benefits of continued therapy outweigh the risks?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
8. What is the indication or diagnosis?	☐ Hypogonadism - Proceed to question **9** ☐ Female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth) - Proceed to question **16** ☐ Other - Proceed to question **24**	
9. Is the patient a male who is 18 years of age or older?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Does the patient have a confirmed diagnosis of hypogonadism as evidenced by morning total serum testosterone levels below 300 ng/dL taken on at least two separate occasions?	☐ Yes Proceed to question **12**	☐ No Proceed to question **11**
11. Is testosterone being prescribed by an endocrinologist or urologist who has made the diagnosis of hypogonadism based on unequivocally and consistently low serum total testosterone or free testosterone levels?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient experiencing signs and symptoms associated with hypogonadism?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Has the provider investigated the etiology of the low testosterone levels?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Has the provider assessed the risks versus benefits of initiating testosterone therapy in this patient?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Does the provider acknowledge that testosterone therapy is clinically appropriate and needed?	☐ Yes Proceed to question **25**	☐ No **STOP** **Coverage not approved**
16. Is the indication for initiation or continuation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)?	☐ Initiation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)- Proceed to question **17** ☐ Continuation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)- Proceed to question **18**	

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17. Is the patient a female active duty servicemember?	☐ Yes (Female active duty servicemembers) – **STOP - Coverage not approved** ☐ No (Female non-active duty servicemembers) - Proceed to question **18**	
18. Is the patient 19 years of age or older?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. Does the patient have a diagnosis of gender dysphoria made by a TRICARE-authorized mental health provider according to the most current edition of the DSM?	☐ Yes Proceed to question **20**	☐ No **STOP** **Coverage not approved**
20. Is the requested medication being prescribed by an endocrinologist or a physician who specializes in the treatment of transgender patients?	☐ Yes Proceed to question **21**	☐ No **STOP** **Coverage not approved**
21. Is the patient a biological female of childbearing potential?	☐ Yes Proceed to question **22**	☐ No Proceed to question **23**
22. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **23**
23. Does the patient have a 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 **STOP** **Coverage not approved**	☐ No Proceed to question **25**
24. Document the requested indication and rationale for use.	_____ Proceed to question **27**	
25. What is the requested medication?	☐ testosterone 1% gel (for example, generic Androgel, generic Testim, etc.) - **Sign and date below** ☐ testosterone 1.62% gel (for example, generic Androgel, etc.) - **Sign and date below** ☐ testosterone 2% solution (for example, generic Axiron, etc.) - **Sign and date below** ☐ Other (for example Androderm, Fortesta (2% testosterone gel multi-dose pump (MDP)), Natesto, brand Testosterone 1% gel packet, brand Vogelxo) - Proceed to question **26**	
26. Has the patient tried and failed a 3-month trial of one of the following medications: testosterone 1% gel (for example, generic Androgel, generic Testim, etc.), 1.62% gel (for example, generic Androgel, etc.), or 2% solution (for example, generic Axiron, etc.)?	☐ Yes **Sign and date below**	☐ No Proceed to question **27**

27. Has the patient experienced a clinically significant adverse reaction to one of the following medications: testosterone 1% gel (for example, generic Androgel, generic Testim, etc.), 1.62% gel (for example, generic Androgel, etc.), or 2% solution (for example, generic Axiron, etc.)?	☐ Yes **Sign and date below**	☐ No Proceed to question **28**
28. Has the patient had a contraindication or relative contraindication to one of the following medications: testosterone 1% gel (for example, generic Androgel, generic Testim, etc.), 1.62% gel (for example, generic Androgel, etc.), or 2% solution (for example, generic Axiron, etc.)?	☐ Yes **Sign and date below**	☐ No Proceed to question **29**
29. Is the request for Androderm or Natesto?	☐ Yes Proceed to question **30**	☐ No **STOP** **Coverage not approved**
30. Does the patient require a testosterone replacement therapy that has a low risk of skin-to-skin transfer?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 4

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

Prescriber Signature _____ Date _____